

## Experiences and dilemmas after 2,000 Hysteroscopies

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The aim of this paper is to point out and help resolve dilemmas in our community based on the six years of experience. These dilemmas concern the hysteroscopy procedure itself and they include: patient preparation, the type of anesthesia, cervical channel dilatation, the type of energy, the surgical technique, possible surgery complications and dealing with them. Work Results The technique of office hysteroscopy and small diameter instruments (Storz, Bettocchi 4 and 5mm) is used at our clinic in its entirety as a good surgical technique but still and mostly under short-lasting intravenous anesthesia or analgesia. In the period from January 2005 to January 2011 at the Department of Obstetrics and Gynaecology, Clinical Centre of Novi Sad, 2,000 diagnostic and operative hysteroscopies were performed. Out of 2000 hysteroscopies there were 304 patients (15.2%) with normal (all clear) results in the cavum of the uterus, 356 patients had pathological results in the cavum and endometrial biopsy had to be performed (17,8%). Since mainly minor lesions in cavum or subtle cavum pathology were registered the additional treatment of those patients was required. The most common minor cavum pathology were strawberry like endometrium micropolyposis, endometriosis and fibrous bands. The most common major pathology of the cavum were polyps which were removed from 720 patients (36%). It was noticed that out of 720 patients even 73 (10.13%) had had to undergo re-hysteroscopy on account of polyps and they had already had the hysteroscopy at our clinic or some other institution in Serbia. Mechanical instruments without the use of any kind of energy were used in that 10,13% patients during those procedures. In almost 95% of polypectomies bipolar electricity was used. Subseptum or septum resection was performed in 260 patients (13%) during which the surgical scissors were used as a mechanical instrument together with the bipolar energy system and Versapoint spring electrode (55%), only the surgical scissors were used in 21 % of the patients and the monopolar resectoscope was used exclusively for large septums (24%). Myomectomy of one or more submucous myomas was performed on 190 patients (9.5%) mainly by using a bipolar resectoscope (65%). In more than 70% of the patients myoma resection was performed in two steps and mainly with type I myoma and type II myoma. The registered complications were 6 uterine perforations (0.3%). In one patient where monopolar electricity was used we had clinical and laboratory symptomatology of water intoxication which was taken care of postoperatively. There were no postoperative infections. Conclusion Operative hysteroscopy is a one-day, safe and exact operative endoscopic procedure. Despite having experience and continuously working there are still dilemmas and controversies but they serve as a starting point for discussions which can lead to finding solutions to every-day problems which may occur. Creating an operative protocol in every institution shows gynaecologists the right way which not only protects patients but gynaecologists themselves from the possible complications.

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