Diagnostic Hysteroscopy Patient Information

Embryo Donation International, P.L.

Please Note:

While many **Embryo Recipients** are couples, these materials use the singular "**I**" to mean all single and couple Embryo Recipients, making it easier to read.

General:

Diagnostic hysteroscopy is the "gold standard" in evaluating the inside of the uterus and is performed on all EDI embryo recipients.

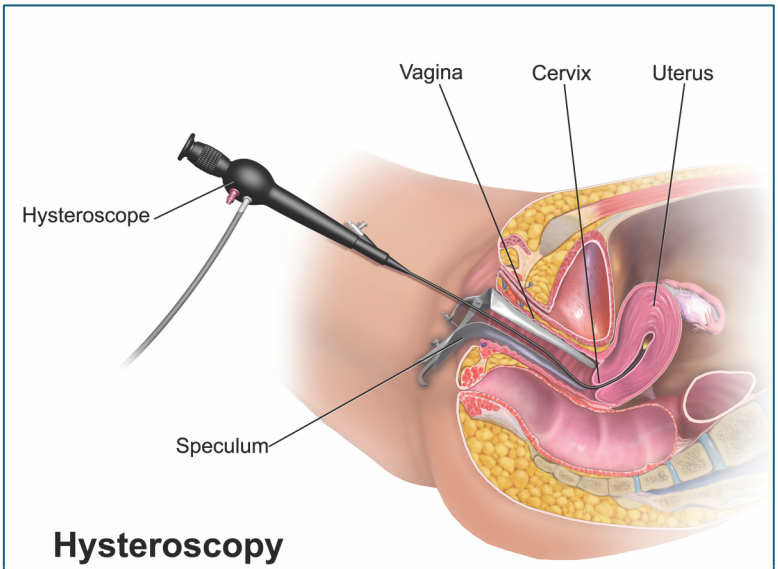

Figure 1: By BruceBlaus-Own work, CC BY-SA 4.0, Click Here.

During this procedure, my clinician gently places a **very small flexible telescope-like instrument (a hysteroscope)** through my cervix and into my uterus. A warmed sterile saltwater solution flows through the scope to gently expand the uterine cavity, allowing the inside to be clearly seen.

The hysteroscope used at Embryo Donation International (EDI) is **very small—about 1/8 inch wide**. EDI uses **flexible hysteroscopes**, which are usually more comfortable than the rigid instruments used in many other programs.

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How it Usually Feels:

Most patients describe the procedure at EDI as a ***stronger menstrual cramp*** or a ***very short labor pain***. On a scale of 0-10, with 10 being the worst, most patients rate the procedure as a 2 out of 10. It is reported to be significantly less uncomfortable than a **hysterosalpingogram (HSG)**, which is used to assess tubal patency.

Cervical dilation is required in less than 10% of patients prior to hysteroscope placement. Dilation will be required more often in post-menopausal patients. Local medication can be injected near the cervix (e.g., paracervical block) for patients who are uncomfortable.

Indications:

Diagnostic hysteroscopy helps my clinician make sure my uterus is healthy and ready for pregnancy. This test may be requested if I have a past history of:

- Abnormal uterine bleeding
- Uterine fibroids
- Endometrial polyps
- Recurrent pregnancy loss
- Intrauterine adhesions (scar tissue)
- A previously abnormal hysterosalpingogram (HSG)

It is also commonly performed before **IVF** or **embryo donation** to make sure there are no uterine **abnormalities that might interfere with embryo implantation or pregnancy**.

What the Test Can and Can Not Diagnose:

Diagnostic hysteroscopy allows my clinician to see problems inside the uterus, such as:

- Uterine polyps
- Fibroids that extend into the cavity
- Intrauterine adhesions (scar tissue)
- Abnormal uterine shape or structure

However, this test **cannot diagnose**:

- Endometriosis
- Hormonal problems
- Blocked or dilated fallopian tubes
- Pelvic structures located beyond the uterine cavity

If a significant abnormality is found, it may need to be treated later with an **operative hysteroscopy**, which is a separate procedure performed with surgical instruments and often anesthesia.

Scheduling:

Diagnostic hysteroscopy is usually performed **between cycle days 6–12**.

- The first day of menstrual bleeding is day 1.
- It is performed early in my menstrual cycle to make certain I am not pregnant.
- The test may be done on other cycle days if I am taking birth control pills or after a negative pregnancy test.

At EDI, my **physical exam**, **pelvic ultrasound**, and **diagnostic hysteroscopy**, all required procedures, are commonly performed during the same visit.

How I Should Prepare:

EDI recommends taking **400-800 mg of ibuprofen (Advil or Motrin)** about **1 hour before the procedure**. This helps reduce uterine cramping. **Naproxen (Aleve)** 1-2 may also be taken instead of ibuprofen. Acetaminophen (**Tylenol)** is another option, although this medication does not reduce cramping as well.

There are **no dietary restrictions**, and I do **not need to fast**. If I am prone to nausea, however, I may prefer to eat lightly before the procedure.

If I am having **pelvic pain or heavy bleeding** on the day of my appointment, I will contact the office because the procedure may need to be rescheduled.

I may bring **my partner, family member, or friend** to the procedure.

What Happens During the Procedure?

The procedure usually takes only a few minutes.

1. I will undress from the waist down.
2. My clinician may first perform a **pelvic exam**.
3. If there are signs of heavier bleeding or unusual tenderness, the procedure may be rescheduled.
4. A **speculum** will be placed in the vagina.
5. The cervix will be gently cleaned with a cleansing solution.
6. The **flexible hysteroscope** will be inserted through the cervix.
7. Warmed sterile saline will slowly fill the uterus, allowing the lining to be seen clearly.
8. I may feel **brief cramping** while the uterus is expanded.
9. I will be able to **see the inside of my uterus** on the TV screen.
10. The procedure is then completed.

After the Procedure?

After the hysteroscopy:

- I may rest in the office for a few minutes.
- I may experience mild cramping or light spotting.
- Sanitary pads are recommended for the first 24 hours. After that, I may use pads or tampons.

Most patients return to normal activities immediately. A slight amount of vaginal discharge (saline) and mild bleeding may occur. I may drive, exercise, shower, or bathe after the procedure. Sexual activity is usually safe **after 24 hours** unless I am told differently.

For discomfort, I may take Ibuprofen (Motrin or Advil), Naproxen (Aleve), or Acetaminophen (Tylenol), although most patients will not need additional medication.

Possible Risks and Complications:

Menstrual-like cramps and slight vaginal bleeding are common. I might be slightly dizzy following the procedure. These feelings resolve rapidly, and severe complications are infrequent.

Hysteroscopy failures are rare at EDI. If this happens, I will need a different procedure will be needed to evaluate my cavity.

Placing a hole through the uterus is a possible, although a very rare, complication of the procedure, and it is essentially impossible with a narrow flexible hysteroscope. This complication has never happened at EDI.

Every attempt is made to minimize the < 1% infection rate associated with the procedure. If an infection does occur, oral or IV antibiotics and hospitalization will be needed. Rarely, as with any pelvic infection, surgery to remove infected organs may be necessary, leading to sterility. Individuals who become infected were most likely previously infected and almost always have underlying severe tubal disease. The procedure rarely initiates a new infection; rather, it reactivates an old underlying infection.

Understanding the Results:

EDI will usually discuss the results with me immediately after the procedure. If an abnormality is found, additional testing or treatment may be recommended.

When Should I Call The Office?

I should call the office if I have:

- Fever of 100.4°F or higher twice, taken four hours apart
- Pain that does not improve with time or medication
- Heavy vaginal bleeding
- Other significant concerns