Office Hysteroscopy Safety and Feasibility in Women Receiving Anticoagulation and Antiplatelet Treatment

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Introduction

More than 60,000 hysteroscopies are performed each year in the UK [1], commonly for either heavy menstrual bleeding (HMB) or postmenopausal bleeding (PMB). This number is expected to increase following recent National Institute for Clinical Excellence (NICE) guidance recommending outpatient hysteroscopy to all women presenting with HMB as opposed to performing a blind pipelle endometrial biopsy [2].

A significant number of women requiring hysteroscopy are on either anticoagulation or antiplatelet therapy, and therefore it is important to establish whether treatment needs to be adjusted prior to hysteroscopy. There is often a reluctance to perform diagnostic or operative hysteroscopy in this group of patients due to bleeding concerns. However, unnecessary interruption of antithrombotic treatment might increase the risk for cardiovascular accident [3] and bridging of anticoagulation may delay diagnosis, particularly in cases of suspected cancer [4].

The British Committee for Standards in Haematology (BCSH) suggests that anticoagulation does not need to be stopped for certain invasive procedures [5]. There is increasing evidence that certain procedures such as dental procedures, joint injections, cataract surgery and certain endoscopic procedures can be performed safely without stopping anticoagulation or antiplatelet treatment. Diagnostic hysteroscopy with target biopsy has been classified as a procedure with low bleeding risk, however there is no evidence supporting the use of hysteroscopy without either stopping or bridging treatment.

Aim

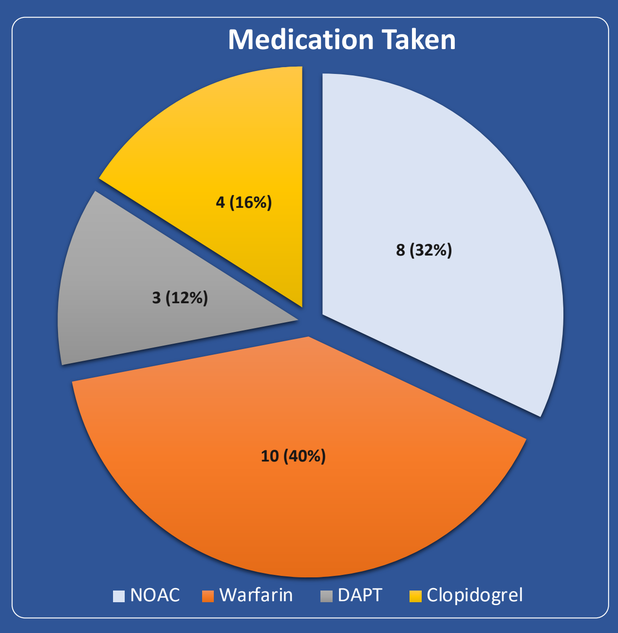
- To assess the safety and feasibility of continuing with antiplatelet or anticoagulation treatment for office hysteroscopy

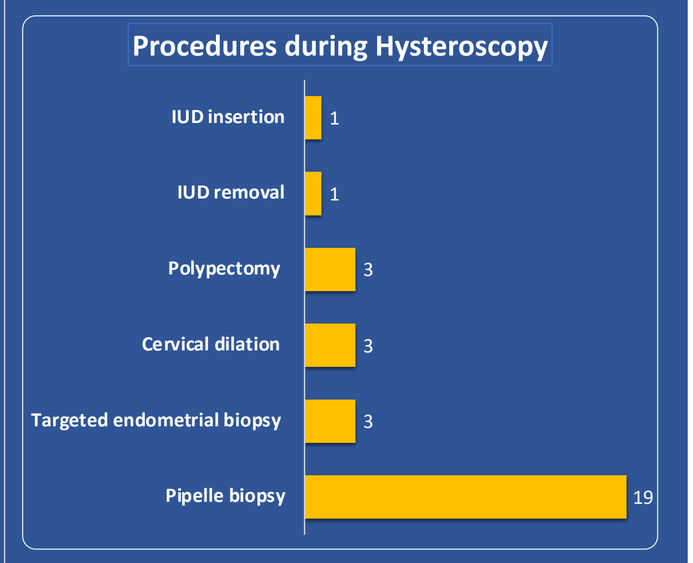
Method

- Retrospective cohort study between June 2019 and June 2020 at St Mary's Hospital, Manchester
- Only women with low risk of bleeding were included. Risk of bleeding was classified based on the anticipated difficulty of the procedure and risk of complications such as uterine perforation as described by the RCOG.
- Saline based office hysteroscopy was performed using the vaginoscopic approach, by gynaecologists or trained specialist nurses according to RCOG standards.

Results

- Twenty-five (25) women aged 40-87 were included
- A variety of minor procedures were performed alongside hysteroscopy. Four cases required local anaesthetic, and the remaining cohort needed no analgesia.





Outcomes

- No significant blood loss
- No inpatient admission required
- Two cases were abandoned –discomfort and false passage
- Three women had an INR >8 with minimal bleeding reported. One case sustained cervical injury, but no bleeding.
- Clear cell tumour (n=1) and atypical endometrial hyperplasia (n=1)

Limitations

- Only low risk procedures were performed without interruption or bridging of treatment. Therefore these results may not be generalizable to procedures with higher bleeding risk.
- Small sample size
- Intra and postoperative bleeding was described as minimal, though this is subject to bias as due to small volumes objective measurement was not feasible

Conclusion

Despite the small number of patients, it appears that interrupting antiplatelet or anticoagulation therapy prior to hysteroscopy is not necessary. Bleeding has been shown to be minimal, even in cases where the INR was raised. A multidisciplinary team approach including gynaecologists, haematologists and cardiologists is importance to establish guidance on managing anticoagulation before hysteroscopic procedures.

More research is needed to establish the safety of performing diagnostic and operative hysteroscopies without bridging or interrupting anticoagulation or antiplatelet treatment. A randomized trial could compare the intra-and postoperative blood loss between a control group whose treatment was stopped/bridged with an uninterrupted treatment group. Until then, these results may serve as reassurance for clinicians undertaking minor hysteroscopic procedures

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