Operative Hysteroscopy Consent Form

This form should only be used if the patient has capacity to give consent. If the patient does not legally have capacity, please use an appropriate alternative consent form from your hospital or hub.

Note to patients: Please note it is common NHS practice for a patient's consent to be taken by a clinician other than the operating or listing surgeon. This clinician will be suitably trained and competent to take your consent. They will be referred to as your 'responsible healthcare professional' in this form.

You may have questions before starting, during or after your procedure. Contact details are provided for any further queries, concerns or if you would like to discuss your treatment further.

Patient details (print or sticker)

First name: _____ **Last name:** _____

Date of birth: _____ **Patient identifier:** _____

Responsible Healthcare Professional: _____

Special requirements: e.g., transport, interpreter, assistance _____

Details of operative hysteroscopy

Operative hysteroscopy procedure:	This procedure involves a thin telescope (hysteroscope) being passed into your vagina and through the entrance of the womb (cervix) to examine the inside of the womb (uterus). The womb is filled with fluid, which passes along the hysteroscope, to make it possible to see inside and perform surgery. You may be awake or asleep (general anaesthesia) during the procedure.
Extra procedures:	Taking samples from the lining of the womb (endometrial biopsy) Removal of: o Polyps (outgrowths) from the lining of the womb (endometrial polypectomy) o Fibroids from the walls of the womb (myomectomy) o Membrane (septa) causing divisions of the womb (septoplasty) o Scar tissue (adhesiolysis) o Fetal tissue or placenta after pregnancy ('retained products of conception') o Womb lining (transcervical resection/endometrial ablation) Insertion of a tube into the fallopian tubes for the purpose of sterilisation, or to overcome a blocked fallopian tube (proximal tubal occlusion)
Indication for, and purpose of surgery: (Tick as appropriate)	The purpose of this procedure is to enable the clinical team to make a diagnosis and/or remove any structures or abnormalities from the inside of the womb (uterus) that may be causing the symptoms. ☐ Obtain a sample (biopsy) of the lining of the womb (endometrium) to enable diagnosis ☐ Treatment of symptoms (e.g., abnormal bleeding, fertility problems) by removing of one or more of the following abnormal structures in the womb: Polyp(s) Fibroid(s) Septum Adhesions Retained products of conception

	☐ Treat heavy menstrual bleeding by removing/destroying the lining of the womb (endometrium) (note this procedure is only suitable for patients who do not require future fertility because by removing the endometrium, fertility is reduced and may even be prevented. Patients are still advised however, to continue to use contraception after the procedure). ☐ Tubal cannulation for overcoming proximal tubal occlusion ☐ Tubal cannulation for sterilisation ☐ Other(s) _____
Alternatives considered: (Tick as appropriate)	☐ **Conservative management** Conservative management is a term used when a condition is managed without surgery or other invasive procedures or treatments. ☐ Other(s) _____

Surgical care during the coronavirus (COVID-19) pandemic

During the current coronavirus pandemic there are additional considerations regarding having an operation in a hospital or hub. We need to make you aware that your surgical care may be disrupted, delayed or performed different during the pandemic.

Despite precautions, coming into hospital might increase your chances of contracting COVID-19, and if you come into the hospital and test positive your operation may be cancelled. If COVID-19 infection occurs when you have surgery or while in hospital, this could make your recovery more difficult, or increase your risk of serious illness or death.

We will do everything we can to perform your operation, keep you safe, and to provide you with information at all stages. Your hospital or hub site will provide you with key information regarding infection control, risks and responses and any further relevant information to you.

Additional resources

Heavy menstrual bleeding (update) – National Institute for Health and Care Excellence
https://www.nice.org.uk/guidance/NG88

Best Practice in outpatient hysteroscopy – Royal College of Obstetricians and Gynaecologists/British Society for Gynaecological Endoscopy
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg59hysteroscopy.pdf

If you do not wish to access the additional patient information contained within this consent form digitally, please speak to your responsible healthcare professional and they will provide you with a hard copy. This will be provided in a language and format that suits you.

Pain Management and Anaesthesia

Operative hysteroscopy can be performed as an outpatient procedure with you awake. In this case, simple pain killers can be taken by mouth before the procedure to reduce pain during and afterwards. You can also choose to take tablets that make you feel more relaxed (oral sedatives) before the procedure, but these do not reduce pain. They may also make you feel drowsy, so you would need to stay in hospital longer and should not drive home or operate machinery for the rest of the day.

During the procedure you can choose to breathe in a gas that may help to reduce pain and anxiety. The most common gas available is nitrous oxide, also known as 'gas and air', which is used by pregnant women in labour.

Local anaesthesia is usually used if the operator thinks that the entrance to the womb (the cervix) needs to be stretched a little (dilated) to be able to perform the procedure. This is normally if the cervix is too narrow for the hysteroscope. Local anaesthetic is not normally given before starting the procedure because it is usually not possible to tell in advance which patients may need the cervix to be dilated. Also, using modern small diameter instruments and insertion techniques it is not clear that local anaesthetic given in advance helps reduce pain and for this reason it is normally used for helping dilate the cervix without pain.

Local anaesthetic is usually injected into the cervix using a small needle. This can sting a little, just like having a needle for an injection or blood test. Sometimes local anaesthetic is sprayed or instilled onto or through the opening of the cervix. Local anaesthesia numbs the cervix to allow the cervix to be dilated painlessly. However, it cannot take away sensation from the inside of the womb where the hysteroscope will need to be inserted.

You can discuss choices of pain control and the risks further with your clinician on the day of your procedure. This is a shared decision-making process, and you will jointly decide and agree the type of pain management that is best for you.

You can choose the type of pain management before the operative hysteroscopy, but you can also request other pain management options not initially chosen during the procedure. If you decide during the procedure that you would like regional or general anaesthesia, or deep intravenous sedation (medicine given by an anaesthetist through a drip to keep you almost asleep but not unconscious) then the outpatient procedure will be stopped immediately and it can be rescheduled at a later date in hospital.

Operative hysteroscopy can also be performed with you asleep. In this case, a general anaesthetic is used to allow surgery to take place painlessly and put you to sleep. It may include medicines that put you to sleep, or those which only numb the area being operated on while you remain awake. This can be done in various ways and your anaesthetist will advise you on your options and talk to you about the risks, complications and benefits of your choice. There is no legal requirement to obtain written consent for the type of anaesthesia given to a patient; this section of the consent form is for your information only.

On the day of surgery, an anaesthetist will discuss anaesthetic options and risks with you. This is a shared decision-making process, and you will jointly decide and agree the anaesthetic option that is best for you. Please remember that if there are any complications during surgery, your anaesthetist may need to alter the type of anaesthesia and they will explain this to you during the procedures.

For further information about the types of anaesthetic you may receive, and potential risks, please see the information below.

Types

Risks

https://www.rcoa.ac.uk/documents/anaesthesia-explained/types-anaesthesia

https://www.rcoa.ac.uk/sites/default/files/documents/2019-11/Risk infographics_2019web.pdf

If you do not wish to access the additional patient information via link or QR code, please speak to your responsible healthcare professional and they will provide you with a hard copy. These will be provided in a language and format that suits you.

Patient name: **Patient unique identifier:**

TO BE FILLED OUT BY CLINICIAN ON THE DAY OF SURGERY:

Name of anaesthetist on the day: Date: _____

_____

□ I confirm I have discussed the different anaesthetic options with the patient, including risks and benefits, and we have jointly decided the preferred anaesthetic.

Please note the preferred methods of anaesthesia as discussed between the patient and anaesthetist below:

You will be told of any additional procedures in addition to those described on this form that may become necessary during your treatment. Please list below any procedures **YOU DO NOT WISH TO BE CARRIED OUT** without further discussion.

Patient name: **Patient unique identifier:**

Immediate risks (during the procedure)

(Your responsible healthcare professional will delete as appropriate)

Expected	**Pain** (*Outpatient procedure only*) If the procedure is performed as an outpatient with you awake, then you will feel some abdominal pain and may feel discomfort during the procedure and immediately afterwards. This pain is usually of mild-to-moderate severity and period-like cramping in nature. You are recommended to take pain relief 30 to 60 minutes before your appointment. If you find the procedure too painful or distressing, then it is important to let a member of your clinical team know and they will stop the procedure immediately. Simple pain killers (analgesics) such as paracetamol and ibuprofen can help to ease pain after the procedure, which is usually of a mild-to-moderate intensity. If the pain is more severe then you will be kept in hospital, offered stronger pain killers and observed for a while until you feel you can manage the pain at home with simple pain killers. Pain normally subsides within 30 to 60 minutes of the procedure.
Common (more than 1 in 20)	**Feeling faint or giddy** (*Outpatient procedure only)* If the procedure is performed as an outpatient with you awake, then this feeling can occur during or immediately after the procedure. You may feel cold and clammy, as well as feel sick or actually be sick. These feelings settle after a short period of lying flat on a reclining couch or bed and drinking water. Occasionally a drip is needed to give you fluids. Sometimes, you might need an injection of medicine to make you feel back to normal. **Unable to complete the procedure, meaning a repeat procedure or different management plan is needed** It may not always be possible to complete the procedure. Reasons why the procedure may not be completed include excessive absorption of fluid, if the clinician is unable to get a good view of the womb, the type and position of the abnormality, equipment issues, or pain (*outpatient procedures only*). The need for further procedures is more common if you are having fibroids or adhesions removed.
Uncommon (fewer than 1 in 20)	**Uterine perforation** This is when a hole (perforation) is made through the muscular wall of the womb (uterus) while inserting the hysteroscope. The hole usually heals by itself and antibiotics are prescribed to prevent infection.
Rare (fewer than 1 in 100)	**Injury with or without excessive bleeding, or damage to the womb (uterus) and/or internal pelvic organs following a uterine perforation** This type of complication requires keyhole (laparoscopic) surgery, or open surgery under general anaesthesia to find and repair any damage. Rarely, a blood transfusion is needed. **Fluid overload** Fluid overload can occur if excess fluid used during the hysteroscopy is absorbed into the bloodstream and cells within the body. It can cause symptoms such as nausea and vomiting, headache and visual changes, numbness and tingling, breathlessness or a frothy cough and confusion. If this happens, you will need to be admitted to hospital for monitoring and medications to help remove the excess fluid. Very rarely, this monitoring needs to be done in an intensive care unit.
Specific risks to you from your treatment (to be input by your responsible healthcare professional)	

Early and late risks (in the days, weeks or months after the procedure)

(Your responsible healthcare professional will delete as appropriate)

Expected	
Common (more than 1 in 20)	**Infection of the genital tract/urinary tract** Infections of the womb (uterus) are called endometritis. They can cause a smelly vaginal discharge, abdominal pain and fever. A urinary tract infection (UTI), commonly known as cystitis, can cause a burning when passing urine and can make you feel like you need to pass urine more often. A short course of oral antibiotic (antibiotic taken by mouth) is needed to treat these infections. **Pain** Simple pain killers (analgesics) such as paracetamol and ibuprofen can help to ease pain, which is usually of a mild-to-moderate intensity. One in five patients report some continuing pain within 2 weeks of the procedure. **Vaginal bleeding** Heavy vaginal bleeding can occur for a short time immediately after the procedure, especially following removal of a fibroid or septum. If small samples of tissue (biopsies) of the lining of the womb (uterus) are taken, a small amount of vaginal bleeding, no more than you would experience during a period, is to be expected following the procedure, You might experience some fresh red, old brown blood, or blood-stained discharge for a few days after the procedure.
Uncommon (fewer than 1 in 20)	**Blood infections and pelvic abscess** Bacteria from the genital tract can occasionally can enter into the blood circulation after a hysteroscopy, causing symptoms such as fever, rigors (feeling hot and cold), nausea and vomiting, tiredness, weakness, abdominal pain and feeling faint. If this happens, you will need to be admitted to hospital for intravenous fluids (a drip) and treatment with antibiotics. Sometimes further tests are needed to rule out damage to internal pelvic organs or collections of pus (abscesses) within the pelvis, which may need further keyhole or open surgery. **Adhesion formation that may affect future fertility** Scar tissue (adhesions) can form during the healing process after abnormalities have been removed from inside the womb (uterus). This may reduce or stop menstrual periods and reduce fertility.
Rare (fewer than 1 in 100)	**Damage to the womb (uterus) and/or internal pelvic organs s following a uterine perforation that was missed at the time of the procedure** Injury that was missed at the time of the procedure can lead to symptoms within a few days, such as severe abdominal pain, fever, and severe tiredness/weakness. If this happens, you will need urgent admission to hospital for fluids, assessment, investigations and antibiotics. Key-hole (laparoscopic) surgery, or open surgery under general anaesthesia may be needed to find and treat or repair any damage. Rarely, hysterectomy (removal of the womb) and/or blood transfusion is needed. **Blood clots (deep vein thrombosis or pulmonary embolus)** Blood clots can form in the veins of the legs (deep vein thrombosis), causing pain and redness in the leg. They are more likely to occur after an operation, when people move around less. Occasionally, these clots can also travel from the legs to the lung (pulmonary embolus) and can cause problems with breathing. Clots in the leg or lung need treatment, such as with blood-thinning medications.
Specific risks to you from your treatment (to be input by your responsible healthcare professional)	

Patient name: _____ **Patient unique identifier:** _____

Statement of health professional

- I am suitably trained and competent and have sufficient knowledge to consent this patient in line with the requirements of my regulatory body.
- I have discussed what the treatment is likely to involve, the benefits and risks of this procedure.
- I have also discussed the benefits and risks of any available alternative procedures or treatments including no treatment.
- I have discussed any particular concerns of this patient.

Patient information leaflet provided: ☐ Yes ☐ No – Details: _____

Copy of consent form accepted by patient: ☐ Yes ☐ No

Signature: _____ **Date:** _____

Name: _____ **Job title:** _____

Statement of patient

Please read this form carefully. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

- I agree to the course of treatment described on this form.
- I have had the benefits and possible risks of treatment explained to me.
- I have had the opportunity to discuss treatment alternatives, including no treatment.
- I understand that if, during an outpatient procedure, I communicate to the clinical team that the procedure is too painful or distressing, then the procedure will be stopped immediately and rescheduled with alternative pain management.
- I understand that a guarantee cannot be given that a particular person will perform the procedure. The person will, however, have appropriate expertise.
- I understand I have been/will be given the opportunity to discuss my anaesthetic options with an anaesthetist, or my pain management options with a clinician (if I have agreed to be awake), and we will jointly decide which option is best for me. I understand that the type of anaesthesia may need to be altered if there are any complications during the procedure.
- I have been told about additional procedures that are necessary prior to treatment or may become necessary during my treatment. This may include permanent skin marks and photographs to help with treatment planning and identification.
- I understand that there may be people present for my procedure who are learning, such as junior doctors, medical students, and trainee nurses, and that I may decline to have any of these people present.

☐ I agree that people who are learning, such as junior doctors, medical students and trainee nurses, may participate in examinations if supervised by a fully qualified professional.

☐ I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

☐ I understand that information collected during my procedure/ treatment, including images and video, may be used for education, audit and research (which may be published in medical journals). All information will be anonymised and used in a way that I cannot be identified.

☐ I agree that my health records may be used by authorised members of staff, who are not directly involved in my clinical care, for research approved by a research ethics committee and in compliance with the Data Protection Act (2018).

☐ I understand that patient specific data will be collected and may be used in the context of providing clinical care, in compliance with the Data Protection Act (2018).

☐ I confirm that I have read and understood pages 1 to X of the consent form above.

Please inform your responsible healthcare professional if you wish to withdraw consent for information use.

Statement of interpreter/ witness (where appropriate)

□ I have interpreted the information contained in the form to the patient to the best of my abilities and in a way in which I believe they can understand.

Patient name:

Patient unique identifier:

or

Name:

□ I confirm that the patient is unable to sign but has indicated their consent.

Signature:

Tick if relevant

☐ I confirm that there is no risk that I could be pregnant.

Please inform your responsible healthcare professional and/or your clinical care team on the day of your procedure if you could be pregnant. Please note that a pregnancy test may give a negative result if a pregnancy has occurred within 2 weeks of the test.

Date:

Name (PRINT):

Signature: