Gyn Office Procedures

Part 1:
1. Cervical or endometrial polyp removal
2. IUD removal
3. Vulvar biopsy (and vulvar lesions)
4. Endometrial biopsy (and interpretation of EMB results)

Part 2:
1. Pessary placement
2. IUD insertion— Copper T and Mirena

Part 3:
1. Nexplanon insertion
2. Manual uterine aspiration with cervical dilation

Cervical Polyp removal

If you aren’t currently doing this, you should! Can remove cervical polyps and small (<2cm) endometrial polyps

Equipment:
1. Ring forceps.
2. Silver nitrate sticks.
3. Optional: allis clamp

Typically well tolerated without anesthesia. Occasionally, twisting is painful and procedure should be done with sedation
Polyp removal

- Clean with betadine
- **If polyp on a stalk,** grasp as high as possible with ring forceps and begin to twist in one direction. When meet resistance in that direction, twist other way. **Do not pull.** Continue twisting process until polyp has been removed. Cauterize base with silver nitrate (helps kill remaining cells)
- **If polyp not on a stalk:** Unlikely that ring forceps will grasp it. Try allis clamp to “chomp it off”. Cauterize base with silver nitrate
- Send to pathology.

IUD removal

- If you aren’t currently doing this, you should.
- No training necessary!
- Most important: offer other form of reliable contraception, if desired.
- **Equipment:**
  - Ring forceps.
  - Cytology brush.
IUD removal

- **If strings visible**, ask pt to cough and pull quickly on strings as she coughs (this helps with the visceral feeling pt will have you remove it).
- **If strings not visible**: try to tease them out by twisting cytology brush within the endocervix.

- **Complications**: none that I know of. String can break off or if IUD embedded you won’t be able to remove it. Occasionally it hurts to remove (usually not).
Vulvar Biopsy

Supplies:
1. Punch biopsy (4 or 5 mm)
2. 1% lidocaine
3. Insulin syringe (not PPD syringe)
4. Suture removal kit (pick-ups and scissors)
5. Gauze/silver nitrate for hemostasis

1. Clean with betadine or alcohol
2. 1% lidocaine in insulin syringe (PPD needles have barbs!). Have her cough as you stab. This hurts a lot!
3. Twist punch on skin as pushing. Push fairly hard. Check intermittently to see if through skin. Easy to go very deep once you penetrate skin.
4. Once circumferentially cut, use pick-ups to lift plug of tissue and cut off with scissors
5. Use pressure to stop bleeding. Silver nitrate if necessary but burns.
Lichen sclerosis et atrophicus
Note loss of normal architecture and white, thin skin

Potential biopsy site

Lichen simplex chronicus
Note thickened skin due to chronic scratching

Potential biopsy site
VIN: Vulvar intraepithelial neoplasia

Note Red macular lesion

Potential biopsy site

Vulvar melanoma: biopsy all irregular shaped hyper-pigmented lesions
Endometrial Biopsy

Supplies:
1. Ibuprofen (Pre-procedure)
2. EMB pipelle
3. 1% lidocaine for 12:00 cervix tenaculum site
4. Tenaculum
5. Fox swabs/silver nitrate for hemostasis

Endometrial Biopsy

1. BME to check size, position of uterus
2. Clean cervix with betadine
3. **Attempt passing pipelle without using tenaculum.** Place pipelle just inside os, she bears down while you push. If it “pops” through the internal os, get your sample as noted below. If it doesn’t pass, you’ll need tenaculum.
4. **Always give lidocaine at tenaculum site.** Good evidence that it decreases pain of the procedure. 2-3 cc 1% lidocaine to 12:00 anterior cervix to get a 1 cm white bleb (I like 22 gauge, 4 in spinal needle). Have her “cough it in”.
5. **Tenaculum:** 1 cm wide bite, slowly close.
6. Pull firmly back on tenaculum as you push pipelle through os. Tenaculum should move about 2 cm.
7. Once pipelle passes or “pops” through the internal os, **push it gently up to fundus and then back it away from fundus by about 1 cm**. Do not push hard against the fundus. Do not repeatedly touch the fundus. **Touching fundus= painful.**

8. **Obtain suction** by pulling the stylette all the way back

9. Move the pipelle up and down within the uterus (below the fundus) while twisting. Count to 10 out loud. Remove pipelle at 10 seconds.

10. Carefully plunge specimen into specimen cup without touching the pipelle to the formalin or sides of cup.

11. Check specimen adequacy by shaking formalin and looking for tissue pieces.

12. If adequate and uterus gritty: done. If not gritty or inadequate: do another pass.
EMB tricks

- Ibuprofen when hits the door.
- Help her with breathing. No breath holding.
- **Count to 10?** Gives her control and a time frame. Tell her you’ll **count to 10** during the biopsy and will stop at 10 (and do so!). If need to do another pass, ask permission—I’ve never had anyone say no (they don’t want to go through this again if insuff sample!)
- If she can’t tolerate, STOP. Offer another visit with ativan, or procedure under sedation, or ultrasound if post-menopausal (no evidence that intrauterine lidocaine is helpful)

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EMB tricks

- If trouble passing pipelle, use different vectors of traction on the tenaculum (up, down, right, left).
- If still can’t pass it and she can tolerate, paracervical block can relax os (~6-8 cc 1% lido or chloroprocaine at 4:00 and 8:00 vag - cervical junction). Can also try os finder, small dilators or ultrasound guidance.
- **If known to be anxious or if attempt and fail, give ativan for next attempt (if pt willing). Works wonders.**
- If known to be atrophic or if fail to place, try again (if patient willing) after giving misoprostol 400 mcg buccal or vaginal, 30-60 min prior
EMB Interpretation & next steps

“Secretory endometrium”?
- Ovulation has occurred. Rules out anovulation. Likely anatomic lesion.

“Proliferative endometrium”?
- Unopposed estrogen effect. Either anovulatory bleeding or first half of cycle.
  - If premenopause: treat as for anovulation (hormonal methods).
  - If post-menopause, give progestin to prevent endometrial hyperplasia.

“Plasma cells”?
- Chronic endometritis: treat with Doxy or Clinda for 2 wks

“Proliferative with stromal breakdown and karyorrhexis” —>
- Classic for anovulation. Prolonged unopposed estrogen effect. Treat as above for proliferative.

“Benign endocervical cells, no endometrium.” —>
- Non-diagnostic. Could be atrophy but without endometrium, can’t rule out neoplasia.

If post-menopausal: Ultrasound to check endometrial thickness. If >=5 mm, needs repeat attempt at sampling (EMB vs D&C).

If pre-menopausal: Repeat EMB. Consider misoprostol pre-treatment (400mcg buccal or vaginal)
EMB Interpretation & next steps

“Benign superficial fragmented endometrium. No intact glands or stroma. No hyperplasia or carcinoma. Suboptimal for evaluation”

→Either atrophy or insufficient sample.
  - **If atrophy suspected clinically:** do not re-sample.
    Observe or add vaginal premarin if vaginal sx. If bleeding persists/recurs→ Ultrasound (if post-meno). D&C if continued blding
  - **If atrophy NOT suspected clinically:** Post-meno: U/S. Pre-meno: resample

EMB Interpretation & next steps

“Simple hyperplasia”
  - 1% chance of progression to carcinoma.
  - Treat with progestin (Mirena is best). Rebiopsy 3-6 months. Follow closely.

“Simple hyperplasia with atypia”
  - Atypia is most important risk indicator for cancer progression.
  - 8% chance of progression to Ca.
  - Progestin (prefer Mirena) or hysterectomy (esp if difficult to follow or biopsies difficult or not tolerated.) Biopsy q3-6 mos until 2 normal.
EMB Interpretation & next steps

Complex, atypical hyperplasia

- 27% chance of progression to Ca.
- And, 30-50% already have co-existing carcinoma.
- Recommend hysterectomy. If refuse, do D&C to rule-out coexisting carcinoma. High dose progestin (Megase) or Mirena IUD. Biopsy q3-6 months until 3 normal. Failure to revert to normal by 9 mos is assoc with progression.

Return

Pessary Placement

Start with these 3 types. Get multiple sizes and keep in office. If these don't work, refer

Ring with support

For prolapse plus incontinence:

- Incontinence dish with support
- Incontinence Ring with knob
**Pessary Insertion**

Test correct size:
1. Have her valsalva—shouldn’t come out
2. Walk around—shouldn’t feel it
3. Urinate—should be able to

F/u in 2 wks and 4 wks for careful vaginal exam to ensure no vaginal ulcerations

Fold it like taco and slide it in vagina. When you feel it reach top of vagina, use your index finger to tilt it up behind the pubic symphysis

**Incontinence Ring:**

Note the knob presses on the urethra

- If post-menopausal: always start premarin cream twice weekly one month prior to placement and continue while uses pessary (to prevent ulceration)
- Placement is trial and error. Guess a size and try it
Removal

Can be tough to remove:
- Hook finger under ring, change angle to dislodge it from under symphysis, then pull out
- Teach self removal and insertion at subsequent visit.
- If unable to do, see her q 6-8 wks for removal, wash, reinsert

IUD insertion: Copper vs Mirena

- Both require tenaculum
- Sounding recommended before insertion
  - I use plastic emb pipelle
- Levonorgestrel can be placed without sterile gloves
- Copper has to be loaded steriley
Copper T IUD Insertion Supplies

- Ibuprofen pre-procedure
- IUD
- Sterile gloves to load IUD
- Speculum
- Betadine swabs
- 1% lidocaine for 12:00 tenaculum site
- EMB pipelle (to sound)
- Tenaculum
- Long, sharp scissors

1. Prepare

- Get all supplies set up (don’t forget scissors, don’t open the IUD yet)
- Prepare the patient:
  - BME to check uterine position and size
  - Betadine to cervix
  - 2-3 cc 1% lidocaine to 12:00 anterior cervix to get a 1 cm white bleb (I like 22 gauge spinal needle). Have her “cough it in”.
  - **Tenaculum**: 1 cm wide bite, slowly close. **YES, you must use a tenaculum!** Tenaculum straightens out the endometrial canal. Without it, increased chance of perforation or of placing IUD below the fundus.
2. Sound the uterus

- I prefer EMB pipelle to metal sound (disposable, less likely to perforate with it)
- Why sound?
  1. Measure depth of the uterus (use this to set the blue “depth gauge” on the device
  2. Check its position (retro, mid, anteflexed)
  3. Most important: to ensure that the IUD will pass through the cervix (so you don’t waste an IUD).

3. Load the Copper T

1. Fully peel back package so IUD is sitting on top.
2. Put on sterile gloves.
3. Place the white plunger rod in the clear insertion tube—use care not to plunge the IUD out the top of the tube!

4. Push ends of the arms of the T downward into the insertion tube. Hold the white plunger in place while you do this.
4. Advance IUD into Uterus

- Gently advance the loaded IUD into the uterine cavity.
- STOP when the blue depth-gauge comes in contact with the cervix or when you reach fundus (light resistance is felt)

5. Release Arms of Copper T

Hold the tenaculum and white plunger rod stationary, while partially withdrawing the insertion tube. This releases the arms of the Copper T.

Arms are down when inside inserter. Withdrawing tube while holding inserter still allows arms to pop up and out. Unlike Mirena, this is done at fundus b/c arms swing lateral and up.
6. Gently push insertion tube to position IUD at fundus

- Gently push the insertion tube up until you feel a slight resistance.
- Hold the white plunger rod stationary.
- This step ensures placement high in the uterus.

7. Withdraw Inserter

Gently and slowly withdraw the inserter tube and white insertion rod from the cervical canal until strings can be seen protruding from the cervical opening.

- Carefully trim strings to 3 cm using long scissors (short scissors can get caught on strings and pull out IUD)
CopperT insertion

- Ibuprofen pre-procedure
- IUD
- Sterile gloves to load IUD
- Speculum
- Betadine swabs
- 1% lidocaine for 12:00 tenaculum site
- EMB pipelle (to sound)
- Tenaculum
- Long, sharp scissors to cut strings

Mirena IUS Insertion Supplies
1. Measure the uterus with EMB pipelle

2. Pull on the nylon strings until the arms of the IUD are inside the insertion tube
3. Position the flange to the length as measured by the sound

4. Insert the IUD and tube until the flange is 1-2 cm from cervical os

Alternatively: Push IUD up to fundus then withdraw 1.5 cm
5. Release IUD arms by pulling back on the blue tab to the white marker Count to 10 to allow arms to fully extend

Arms are up while inside inserter. Pulling back blue tab releases the arms so they are initially straight up and then open laterally. Need space for this to occur which is why you need to be 1-2 cm below the fundus.

6. Push the IUD to the fundus (flange at the os).

The device has “memory” and if it has been inside the inserter too long, the arms tend to stay upright instead of bending laterally. Counting to 10 gives time for them to bend laterally and stay that way (prevents inadvertent removal of device as you withdraw inserter)
7. Release the IUD by pulling the blue tab all the way back

8. Withdraw inserter and cut strings to 3cm with long scissors
Uterine Aspiration

- Safe way of removing uterine contents
- Can be used for endometrial biopsy, early pregnancy loss, abortion, and management of septic abortion
- Highly effective
- Can be done in outpatient / ED setting
- There is generally no need to do sharp curettage after
First-Trimester Uterine Aspiration

Dilation and aspiration
VIN: Vulvar intraepithelial neoplasia
Note raised white plaques

Potential biopsy site

VIN: Vulvar intraepithelial neoplasia
Note brown macular lesion

Potential biopsy site