Common Office Gyn Procedures: Tips, Tricks and Pain Control

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Acknowledgements to Jody Steinauer, MD, MS

Disclosures

Dr. Meckstroth receives an honorarium from Danco, Inc. to serve as an expert for an FDA-mandated hotline for clinicians with questions regarding medical abortion.

Office Procedure or Not?

- My skills
- Safety
- Pain/comfort

Gyn Office Procedures: Overview

- Pain and comfort
- Procedures we could talk about:
  - Polyp removal - cervical or endometrial
  - IUD removal
  - Pessary placement
  - IUD insertion: Now there are 5!
  - Endometrial biopsy
  - Manual uterine aspiration with cervical dilation
Components of Pain

- Location
- Intensity
- Quality
- Attention
- Meaning of situation
- Anxiety
- Fear
- Depression
- Motivation-affective component
- Sensory-discriminative component
- Cognitive-evaluation component
  Thought concerning the cause and significance of the pain
  Past experience

The Peak-End Rule

- People judge an experience largely based on how they felt at its peak (most intense point) and its end, not on the sum or average
- "Duration neglect" - judgment of unpleasantness of painful experiences depends little on the duration

Cultural Differences and Pain

- Cultural differences exist in the understanding and report of pain
- Unfair and unhelpful to make assumptions
- Multiple studies document inferior treatment of acute (ED) and postoperative pain in U.S. minorities

Physician characteristics and acute pain

- Physician non-white race associated with significantly better pain treatment in ED (in Mobile, Alabama)¹
- Provider gender as opposed to patient gender was a factor:
  - Female physicians more likely to administer analgesics than male physicians (66% vs 57%, P = 0.009)²

¹ Heins J Pain 2010; 2. Safdar Pain Medicine 2009

AMA Pathophysiology of Pain 2005

Fredrickson and Kahneman 1993 and many after

Factors Associated with Discomfort with Routine Pelvic Exams

- Mean pain 3.2/10
- 17% had pain of 6-10/10 with pelvic exam
- 30% of those with a history of sexual abuse
- Factors associated with high pain:
  - Age < 26 (OR=2.75)
  - Presence of one or more mental health problems (OR=1.9)
  - History of sexual abuse (OR=1.85)
  - Dissatisfaction with present sexual life (OR=1.7)
  - Negative emotional contact with the examiner (OR=8.2)

Adjusted odds ratios, Hilden et al., Acta Ob G Scand. 2003

Creating rapport is pain control.

Minimizing Pain with a Speculum: 201

- Gel lubrication significantly decreases pain
- Use the right size (shortest possible for uterine procedures, open angle for large buttocks)
- Avoid scraping sensitive anterior wall
- Don’t open more than needed.
- Avoid “popping” the cervix into view or snapping it at time of speculum removal
- Don’t push legs apart. “Let your knees relax to here”
- Give women the time they need to relax their hips (“heavy hips”, “all your weight on your hips”)

Language considerations...

- “Relax”
  - “Let these muscles relax on to the table”
  - “try taking a deep breath”

- You might feel “a pinch” or “a stick and a burn”
  - You might feel “something/a twinge”

- “You’re doing great”
  - “I can see you’ve had practice with relaxation.”
  - “It’s a natural reaction to lift up. I’ll just touch here until you are able to let these muscles relax.”
Strategies for Acute Pain

Multimodal pain management
- More than 1 class of meds or analgesic technique
- local +/- NSAID +/- narcotic +/- benzo +++
  nonpharmacologic strategies

Preemptive analgesia
- Intervention more effective PRIOR to tissue injury
- Increased pain response to subsequent stimulation ("wind-up" or "hyperanalgesia")

NSAIDs
- Inhibit synthesis of PG’s by COX enzymes in peripheral tissues and CNS
- COX-2 selective ↓ GI risk/side effects
- Little difference in efficacy in population
- "Large inter-individual difference"
- Ibuprofen: nonselective, most common, minimal effect on platelet aggregation
- Modest reduction in intra- & post-uterine procedure pain

Nonpharmacologic pain management
- Patient control: participation in decisions
- Counseling techniques (Positive suggestion, guided imagery)
- Diversion of attention “Vocal local”
- Visual distraction (ceiling art)
- Heat: continuous low abd heat as effective as ibuprofen for dysmenorrhea
- Music (but not pt choice by headphones)
- Less available: Acupuncture, Hypnosis

Local Anesthesia
Other specialties expect it to work.

They aim to block all the nerves they will irritate and use as much as needed within safety range

“I would never do a block and not test it to be sure it worked.”
-Dentist to me, 2003

References:
- Carwile, JLGTD 2014
- Cepeda, Cochrane Review 2006
- Contrac 2012
- Kotani, Anesth 2001
- Famonville, Pain 1997
Cervical & uterine nerves

Uterine fundus
Sym pathetic nerves via:
• infundibulopelvic pelvic ligament → utero-ovarian lig
• inf hypogastric nerve through uterosacral ligaments T10 - T1

Lower uterus/cervix
• Parasympathetic Frankenhauser plexus lateral to cervix, S2 - S4

Sensory nerves!

Safe Dosing of Lidocaine

• 300 mg max dose for an adult (30 mL of 1%)
• (200 mg in pregnancy if term fetus considered)
• 4.5 mg/kg without epinephrine =
  – 22 mL for a 50 kg (110 lb.) patient
  – 30 mL for a 68 kg (150 lb.) patient
  – 40 mL for a 90 kg (200 lb.) patient (beyond max. dose)
• 7 mg/kg with epinephrine (similar effect to vasopressin)

Variables in LA effect

• Dose, volume and concentration
• Distance to nerves, size/type of nerves
• Tissue perfusion (vasodilation)
• Temperature and pH of solution
• Depth and rate of injection

Bottom Line: TEST for anesthesia before beginning procedure and add more if safe

Cervical blocks can HURT

• Most painful part of procedure sometimes
• Deep blocks hurt more
• Minimize pain with block:
  – Small gauge needle (25-27G)
  – Slow injection
  – Inject ahead of needle
  – Buffered lidocaine (2mL in 200 mg lidocaine)
  – Topical anesthetic first

Tingalser. Repro bio & endoc 2006

Tenaculum placement

- If you place it, you’ll likely USE it
- More stretch receptors than pinpoint
- Most effective: Intracervical injection
  - Also helpful: Forced cough
  - I use 3-5 mL with 25G needle (spinal or 1.5 in) and think no one should EVER feel a tenaculum placed.
  - 1-2 mm deep and inject slowly

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Cervical Injections

Paracervical vs. Intracervical

Superficial vs. Deep injection

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Intrauterine anesthesia

- EMB & lost IUC removal: 5mL 2% lidocaine - significant improvement
  - Sonohysterography: improved pain 5.0 → 3.9/10
  - HSC: Mixed evidence
  - MVA: 5mL of 4% lidocaine led to 2-point/10 improvement

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Intrauterine anesthesia

- 5mL 2% lidocaine
  - 16 or 18 gauge angiocath
  - Advance through cervix, SLOW infusion into cavity
  - Hold syringe at cervix for 2 minutes
  - Can combine with para/intracervical block

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Intra-myometrial injections

With a 22G spinal needle
Like intrauterine:
• Aim to reach fundus and myometrium
Unlike intrauterine:
• Get tissue distension
• Fluid doesn't drain out
• No question about absorption through decidua
• Don't need diff equipment

Superficial on the outside and the inside
(hurts)

Local Anesthesia: Combining Evidence to do Better

• Larger dose – 20 ml of 1% is not enough in many studies of aspiration and it is safe to use more. Add MORE if patient feels any pain with dilation or significant pain with uterine involution.
• Minimize pain with block – Buffer. Inject ahead of the needle. Small gauge. Topical gel or spray.
• Aim for all nerves you will stimulate – attempt to reach fundal nerves.
• Wait till it works – RCT’s without difference, obs studies, pharmacokinetics, neurobiology say yes.

Gyn Office Procedures: Overview

Procedures:
1. Polyp removal - cervical or endometrial
2. IUD removal
3. Pessary placement
4. IUD insertion—LNG IUDs, Copper T
5. Endometrial biopsy
6. Manual uterine aspiration with cervical dilation

Cervical Polyp Removal

If you aren’t doing this, you should!
• Can remove cervical polyps and small (<2cm) visible 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 block or 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 (helps with the visceral feeling pt often has when you remove it)
- If strings not visible: try to tease them out by twisting cytology brush within the endocervix.

  Complications: String can break off or if IUD embedded you won’t be able to remove it or will remove part.
  Occasionally it hurts to remove (usually not).
Endometrial Biopsy

Supplies:
1. Ibuprofen (Pre-procedure)
2. Betadine swabs
3. EMB pipelle (or)
4. 1% lidocaine for tenaculum site (or more)
5. 25G needle, syringe, 18G needle to draw
6. Tenaculum
7. Fox swabs
8. silver nitrate sticks

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 a tenaculum.
4. Always give lidocaine at tenaculum site. Good evidence that it decreases pain of the procedure. 3+ cc 1% lidocaine to 12:00 anterior cervix to get a 1 cm white bleb
5. Tenaculum: 1 cm wide bite, slowly close. (shouldn’t feel it after block)
6. Pull firmly back on tenaculum as you push pipelle through os. Tenaculum should move about 2 cm.

EMB Tricks

- Ibuprofen ASAP
- Talk about pain BEFORE
- Help her with breathing. No breath holding.
- If need to do another pass, ask permission
- If she has pain, STOP.
  – Consider more block.
  – Offer another visit with ativan or sedation and block
  – Consider ultrasound if post-menopausal
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:
  - Cervical block can relax os
  - Os finder, small dilators and/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 prior failure, try again (if patient willing) after giving misoprostol 400 mcg buccal or vaginal, 2-3 hours 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

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EMB Interpretation & Next Steps

- “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 r/o neoplasia.
  - If post-menopausal: Ultrasound to check endometrial thickness. If >=5 mm, needs repeat attempt at sampling (EMB vs D&C vs HSC).
  - If pre-menopausal: Repeat EMB. Consider misoprostol pre-treatment (400mcg buccal or vaginal) and ultrasound

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-menopausal). D&C or HSC if continued bleeding
    - 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 (LNG-IUD 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 Cancer
  – Progestin (prefer IUD) or hysterectomy (esp if difficult to follow or biopsies difficult or not tolerated.) Biopsy q3-6 mos until 2 normal.

• Complex, atypical hyperplasia
  – 27% chance of progression to cancer
  – And, 30-50% already have co-existing carcinoma.
  – Recommend hysterectomy. If declines, do D&C to rule-out coexisting carcinoma. High dose progestin (oral or IUD) Biopsy q3-6 months until 3 normal. Failure to revert to normal by 9 mos is associated with progression.

Pessary Placement

1. Ring with support
   For prolapse plus incontinence:
2. Incontinence dish with support
3. Incontinence Ring with knob

Start with these 3 types. Get multiple sizes and keep in office.
Sizes 3, 4, 5 most common
If these don’t work, refer

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

Follow up visit in 2 wks and 4 wks for careful vaginal exam to ensure no vaginal ulcerations

Fold it like taco and slide it in vagina, fold toward bladder. Use lubricant!
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.

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 & LNG

- Both require tenaculum
- Sounding recommended before insertion (unless using ultrasound)
  - Can use a plastic EMB pipelle
- Levonorgestrel can be placed without sterile gloves
- Copper has to be loaded with sterile gloves
- Have discussion about pain

Pain with IUD insertion, nulliparas

- Data from Ngo et al. ObGyn 2015
**Local anesthesia for IUD**

### Intrauterine

<table>
<thead>
<tr>
<th>Labellarine</th>
<th>Controls</th>
<th>Mean Difference</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdo, 2010</td>
<td>24</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Abdo, 2013</td>
<td>36</td>
<td>27</td>
<td>38</td>
</tr>
<tr>
<td>Mody, 2012</td>
<td>41</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Mody, 2013</td>
<td>46</td>
<td>34</td>
<td>33</td>
</tr>
</tbody>
</table>

### Paracervical

<table>
<thead>
<tr>
<th>Labellarine</th>
<th>Controls</th>
<th>Mean Difference</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdo, 2011</td>
<td>26</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Mody, 2013</td>
<td>26</td>
<td>27</td>
<td>27</td>
</tr>
</tbody>
</table>

Test for trend: Z = 1.42 (P = 0.15)

- **Pain with IUD Insertion**

  - **(Mody)** Paracervical block 10mL of 1% lidocaine, 3 min.

<table>
<thead>
<tr>
<th></th>
<th>BLOCK (median, quartile 1 &amp; 3)</th>
<th>No BLOCK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain w block</td>
<td>40 (19, 69)</td>
<td></td>
</tr>
<tr>
<td>Pain w insertion</td>
<td>24 (3, 73)</td>
<td>62 (8, 77)</td>
</tr>
<tr>
<td>Pain 5 min after</td>
<td>12 (2, 25)</td>
<td>17 (3, 35)</td>
</tr>
</tbody>
</table>

- Misoprostol generally worsens pain. ONLY helpful for insertion in the case of prior insertion failure.
- Topical lidocaine or blend 4%+: some improvement

### IUD Types

<table>
<thead>
<tr>
<th>IUD</th>
<th>Copper T</th>
<th>Mirena</th>
<th>Liletta</th>
<th>Kyleena</th>
<th>Skyla</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hormone</td>
<td>none</td>
<td>LNG</td>
<td>LNG</td>
<td>LNG</td>
<td>LNG</td>
</tr>
<tr>
<td>Dose</td>
<td>-</td>
<td>52 mg</td>
<td>52 mg</td>
<td>19.5 mg</td>
<td>13.5 mg</td>
</tr>
<tr>
<td>Release</td>
<td>-</td>
<td>20 mcg/d</td>
<td>20 mcg/d</td>
<td>17.5 mcg/d</td>
<td>14 mcg/d</td>
</tr>
<tr>
<td>Years of use</td>
<td>10-12 (appr 10)</td>
<td>5-7 (appro 5)</td>
<td>5-7 (appro 3)</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Special issues</td>
<td>Non-hormonal, heavier bleeding</td>
<td>Low systemic, 90% less bleeding</td>
<td>Generic Mirena, non-profit company</td>
<td>Smaller, little lower dose, less amenorrhea</td>
<td>Smaller, v. low dose, no ovarian change</td>
</tr>
</tbody>
</table>

### All IUDs: Insertion Supplies

- Ibuprofen pre-procedure
- IUD
- Sterile gloves to load Cu-T IUD
- Speculum
- Betadine swabs
- 1% lidocaine for tenaculum site or more
- EMB pipelle (to sound)
- Tenaculum
- Long, sharp scissors to cut strings
- Fox swabs silver nitrate (if bleeds at tenac site)
All IUDs: Prepare for IUD Insertion

• Get ALL supplies set up
• Prepare the patient:
  – BME to check uterine position and size
  – Betadine to cervix
  – 1% lidocaine to tenac site. More block if decided to.
  – 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.

ALL IUDs: Sounding 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 “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).

 ALL IUDs: Position the flange to the length as measured by the sound

 ![Diagram of IUD positioning](image)

 All IUDs: Cut strings to 3cm with long scissors

 ![Diagram of scissors cutting threads](image)

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*Do not apply tension or pull on the threads when cutting*

Open scissors completely to check that strings cut
Copper-T Insertion

Cu-T: Loading

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! FINGER ON TOP
4. Push ends of the arms of the T downward into the insertion tube. Hold the white plunger in place while you do this.

Cu-T: 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)

Cu-T: Release Arms

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

Cu-T: 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)

LNG IUD Inserters

Mirena, Kyleena, Skyla
Inserter works the same. Smaller for Kyleena & Skyla

Liletta has strings visible and a 2-piece thumb lever

LNG IUDs: Setting the IUD

Liletta
- Flatten IUD arms
- Put thumb on blue tab and push up as you pull string to set IUD into the tube
- Cleat strings at base
- Keep your thumb on the blue tab

Mirena, Kyleena, Skyla
- Slide thumb tab UP towards IUD to set IUD into the tube
- If it slides back, it cannot be reset and is TRASH
- Keep your thumb on the tab
All LNG IUDs: Insert until the flange is 1-2 cm from cervical os

Alternatively: Push IUD up to fundus, then withdraw 1.5 cm

All LNG IUDs: Release IUD arms by pulling back on the tab to the line. 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.

All LNG IUDs: 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)

All LNG IUDs: Release the IUD by pulling the tab all the way back
All LNG IUDs: Withdraw inserter SLOWLY and cut strings to 3cm with long scissors

New LNG IUD 52mg Insertion and Summary Video

- [https://www.lilletahcp.com](https://www.lilletahcp.com)

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
Uterine Aspiration Supplies

- Betadine
- Local anesthetic
- Dilators
- Manual uterine aspiration equipment
- Ultrasound (optional)

First-Trimester Uterine Aspiration