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SPECIAL ARTICLE

Gynecology

FIGO-GCH joint consensus statement on the current status and recommendations for the use of blind intrauterine procedures in the evaluation and management of women with suspected intrauterine pathologies

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Abstract

Historically, blind intrauterine procedures such as dilation and curettage (D&C) and blind endometrial biopsies have been the primary approach for diagnosing and managing intrauterine pathologies. However, these techniques lack direct visualization, leading to diagnostic limitations, incomplete treatment, and increased complication rates. Despite substantial advances in hysteroscopic technology, including high-definition imaging and minimally invasive instruments, blind procedures remain widely used. This paper examines the limitations of blind intrauterine procedures, underscoring the advantages of hysteroscopy, which provides real-time visualization and allows for more accurate, targeted interventions. With the adoption of the "See and Treat" philosophy, hysteroscopy enables nearly 90% of procedures to be performed in an office setting, enhancing both patient convenience and outcomes. FIGO and GCH advocate for the gradual replacement of blind procedures with hysteroscopic approaches whenever feasible, noting that hysteroscopy improves diagnostic accuracy, reduces risks, and minimizes the need for repeat interventions. Recommendations include expanding access to hysteroscopy through targeted training, especially in low- and middle-income countries, where financial and logistical barriers limit access to advanced gynecological care. Furthermore, this paper emphasizes the importance of patient-centered care, encouraging transparent counseling to support informed decision-making.

KEYWORDS
blind intrauterine procedures, diagnostic accuracy, hysteroscopy, intrauterine pathology, minimally invasive gynecology

1 | INTRODUCTION

The use of blind intrauterine procedures has been historically considered the gold standard for the evaluation and management of women with intrauterine pathology since the introduction of the dilation and curettage (D&C) procedure in 1846.[1–3]

Despite great technological advances in the medical field and the introduction of innovative hysteroscopic surgical instruments and techniques that allow easy endoscopic access to the uterine cavity, blind intrauterine procedures are still highly used in today's gynecologic practice, without significant progress since the 1800s.[4–7]

The Pipelle® endometrial suction curette, the Novak curette, and other blind diagnostic tools, such as sharp curettage, are still being used for diagnostic and therapeutic purposes for patients with intrauterine pathology.[8–10]

In recent years, hysteroscopy has reached significant milestones in terms of the diagnosis and treatment of intrauterine pathologies. Indeed, the advancement of technology, through the introduction of miniaturized instrumentation and the use of an atraumatic vaginoscopic approach, has allowed the widespread use of hysteroscopic diagnostic and operative procedures.[11–13]

Another significant improvement in clinical gynecologic practice is the introduction of the "See and Treat" philosophy, a concept that highlights the option of performing nearly 90% of all hysteroscopic surgeries in the office setting.[12,14–17]

2 | PROGRESS IN HYSTEROSCOPIC TECHNOLOGY

With the progress of technology, we have witnessed a fast development of new optics with smaller diameters and improved image quality, which has been incorporated into modern hysteroscopic devices.[11–13] In addition, the integration of digital cameras and high-definition monitors has enhanced the visualization and documentation of intrauterine pathologies.

Despite the above-mentioned significant progress in hysteroscopic technology, blind D&C is still widely used in clinical practice for the diagnosis and treatment of women with intrauterine pathology.[1–3,11–13]

3 | LIMITATIONS OF BLIND INTRAUTERINE PROCEDURES

Blind intrauterine procedures, such as D&C and blind endometrial biopsies, have several limitations. These include the following:

- Lack of direct visualization of the uterine cavity, which can lead to missing focal pathology or the incomplete removal of intrauterine lesions, as well as unintended damage to the surrounding endometrium and myometrium.[1–3,8–10]
- Inability to accurately diagnose the type and extent of intrauterine pathologies, which can result in incorrect or incomplete treatment.
- Higher rates of complications, such as uterine perforation, cervical laceration, and bleeding, when compared to hysteroscopic procedures.
- Higher rates of incomplete removal of intrauterine lesions, such as polyps, fibroids, and retained products of conception, leading to the need to perform multiple procedures.
- Identification of the source of abnormal uterine bleeding, as blind procedures may not reveal the underlying cause.
- Limitations in the management of complex intrauterine pathologies, such as Asherman's syndrome, congenital uterine anomalies, and cesarean scar defects, where hysteroscopic evaluation and treatment are essential.

We acknowledge that adopting hysteroscopy is not without drawbacks, which include the need for adequate pain management during the procedure.[18] While complications such as uterine perforation, intrauterine adhesion formation, vasovagal reaction, vaginal bleeding, and anxiety during the procedure are possible, it is important to emphasize that these are infrequent, particularly in the office-based setting.[19] Large studies have shown the overall complication rate for hysteroscopy to be less than 1%, with even lower rates in experienced hands and outpatient settings.[19]

4 | RECOMMENDATIONS

FIGO and GCH call for a gradual phasing-out, where feasible, of the use of blind intrauterine procedures for the evaluation and management of patients with suspected intrauterine pathology.

We recommend the following:

- Hysteroscopy should be included in the evaluation of patients with suspected intrauterine pathologies, as it enables direct visualization of the uterine cavity allowing a more accurate diagnosis and targeted treatment.
- Blind intrauterine procedures should be gradually replaced by a hysteroscopic-guided approach, which improves diagnostic accuracy and reduces the risk of missing or misdiagnosing intrauterine pathologies.
- In situations where hysteroscopy is not feasible or available, healthcare providers should consider the use of alternative imaging modalities, such as transvaginal ultrasound and saline infusion sonography, as a means of assessing the uterine cavity and guiding intrauterine procedures.

5 | CONCLUSIONS

In conclusion, FIGO and GCH recommend, whenever feasible, the use of hysteroscopic/direct visualization techniques for the

evaluation and management of women with suspected intrauterine pathology. The adoption of hysteroscopic techniques, which provide direct visualization of the uterine cavity, has been shown to improve diagnostic accuracy, enhance targeted treatment, and reduce the risk of complications associated with blind procedures. However, we acknowledge that in low- and middle-income countries, the widespread implementation of hysteroscopic-guided intrauterine procedures remains a challenge. While the benefits of hysteroscopy are well-established, the costs and limited availability of the necessary equipment and expertise often pose significant barriers to its adoption in resource-constrained settings. Initiatives to educate and train healthcare providers and promote the use of hysteroscopic procedures need to be widely implemented.

- In settings where blind intrauterine procedures are still performed, FIGO and GCH strongly recommend a gradual replacement with hysteroscopic alternatives, advocating for their complete adoption as resources and training become available.
- More efforts are needed to overcome the cultural and social barriers that hinder the acceptance of these minimally invasive techniques.
- The widespread implementation of hysteroscopic procedures will lead to better patient outcomes, more effective management of intrauterine pathologies, and better quality of care for women.
- Global efforts to increase the availability and affordability of hysteroscopic procedures are crucial to ensure that all women have access to the benefits of this diagnostic and therapeutic modality.
- FIGO and GCH recognize the negative impact of blind intrauterine procedures on women's safety and promote access to adequate health care for women worldwide.
- Women must be able to actively participate in the surgical decision-making process. It is crucial that patients receive complete and detailed counseling about the risks and benefits of each treatment option, allowing them to make an adequate informed decision regarding management.
- FIGO and GCH promote quality continued medical education that allows professionals to offer patients the best options according to individual health conditions.
- FIGO and GCH also discourage the provision of surgical procedures by unqualified personnel in suboptimal settings. Proper training makes it possible to reduce complication rates and decreases the burden that benign gynecological surgeries exert on society.
- FIGO and GCH recommend that affiliated societies implement local and regional mechanisms to facilitate access to adequate gynecological care and support development of health policies that reduce the access gap for women.
- FIGO and GCH are committed to universal gynecologic health coverage and work as hard on creating preventive care strategies as they do on access to the best medical, surgical, and emergency gynecologic care.

AUTHOR CONTRIBUTIONS

All authors contributed to the conception, design, writing and review of the paper. All authors agree to be accountable for the final publication.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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