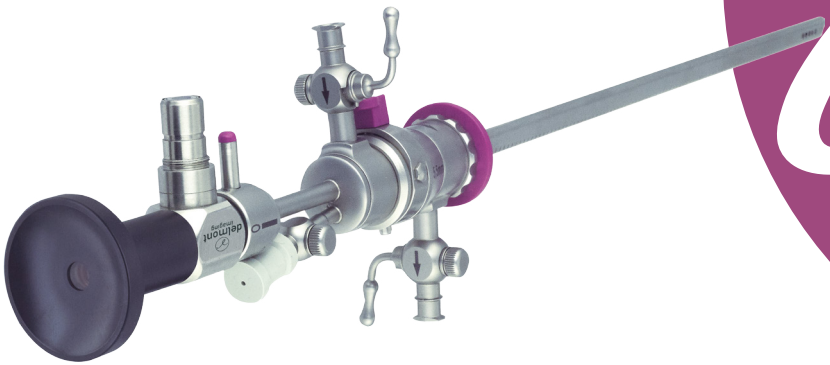
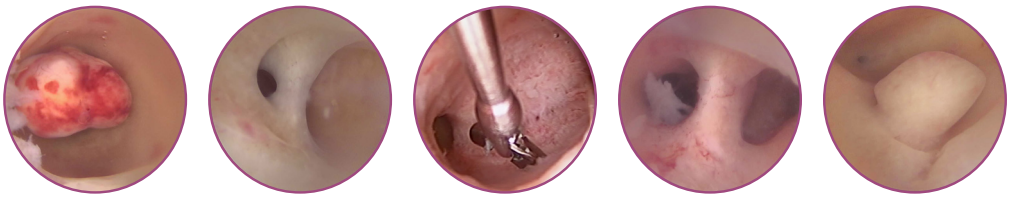
imaging all the women



EasyCare

Clinical applications



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imaging

EasyCare

"EasyCare is a set of instruments developed to treat the different pathologies addressed in this document. The small diameter of these instruments and the absence of energy make it the ideal tool for nulliparous women, infertile couples, and menopausal women or with a stenosed cervix.
In the present context oriented towards the realization of more and more acts in the office rather than in the operating theatre, it is essential to be equipped with atraumatic but powerful tools.
With a restrained outer diameter (5mm) 95% of patients can be treated by vaginoscopy. With an operative canal allowing the use of efficient instruments (7Fr.), your surgical skill will be safe and efficient."

Pr. Hervé Fernandez,
Head of OB/GYN Dpt.
Kremlin Bicêtre Hospital. France

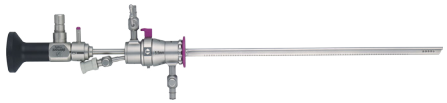
Set composition

1 HD Hysteroscope, 2.9mm, 30°
to provide sharp images of the entire uterine cavity.

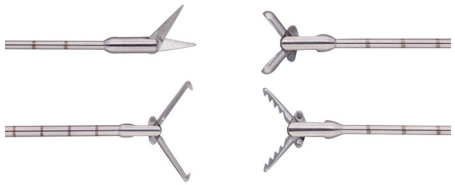
2 4mm Diagnostic Sheath
with rotatable stopcock.

3 4.9mm Inner Operating Sheath
with 7Fr. Operative channel. The best tool to perform "See & Treat" in office.

4 5.5mm Outer Operating Sheath
to perform major surgical procedures in the operating theater.



5 4 instruments to approach all situations. They are graduated to ease your surgical marks.

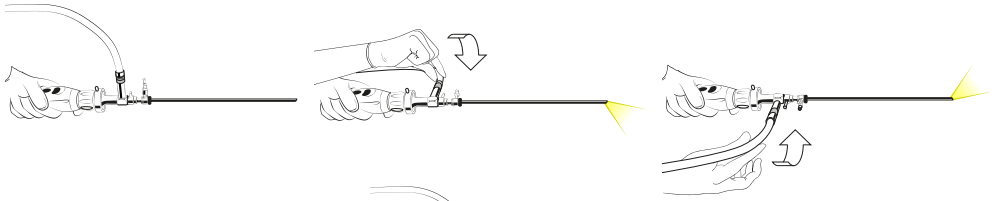


6 A light cable and its adapters.

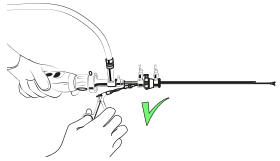
Correct handling

Some recommendations and tips that will ensure you a better working comfort:

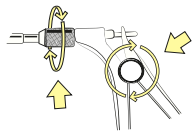
1 Take advantage of the 30° direction of view during diagnostic hysteroscopy.



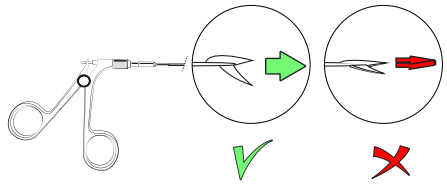
2 Good handling of the instrument and the operating sheath.



3 Make sure the 2 screws of the instrument are tight before use.



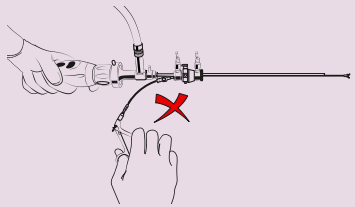
4 Special case: make sure that the removable blade of the scissors is well aligned with the handle before tightening.



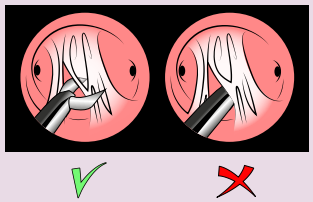
To avoid

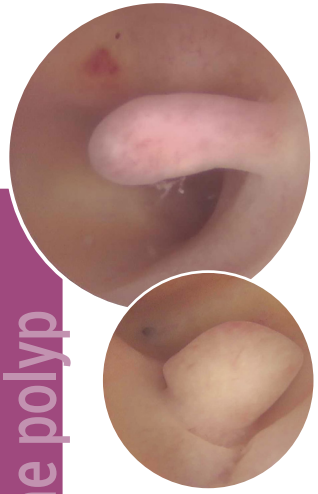
For the well-being of your patient, but also for a longer life of your instruments:

- Do not bend instruments while handling in the operative channel.



- Always keep the operating instruments visible.





The polyp

Definition

Uterine polyps are protrusions of the endometrium or endocervix. Their size varies from a few millimeters to several centimeters. They are often asymptomatic but may be the cause of abnormal bleedings or infertility.

Treatment

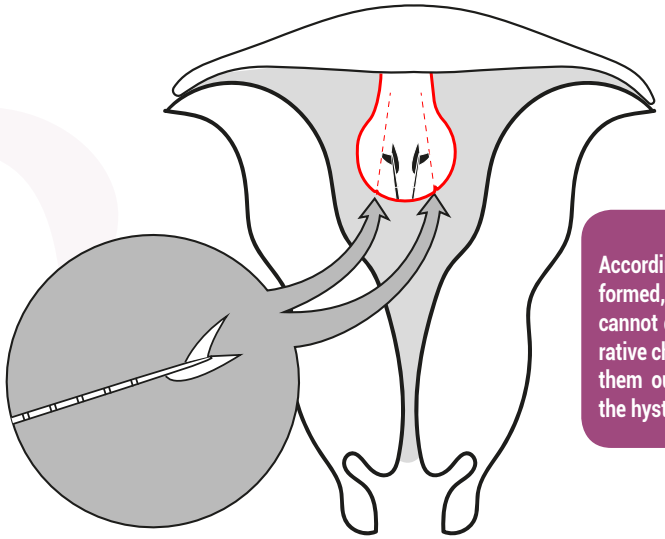
In case of infertility or of age > 40 years, they must be removed. In the other cases, and especially for polyps < 15mm, they can resolve and need to be re-controlled before any operatory indication.

Surgical method

Slices must be cut transversely without detaching them, and not come loose from their pole of implantation in the uterine cavity. The number of slices is to be adapted according to the size of the polyp.

Do not cut the foot of the polyp first for it will be difficult for you to slice it into several pieces for extraction.

The extraction is carried out using 7Fr. grasping forceps, Pozzi or standard one.



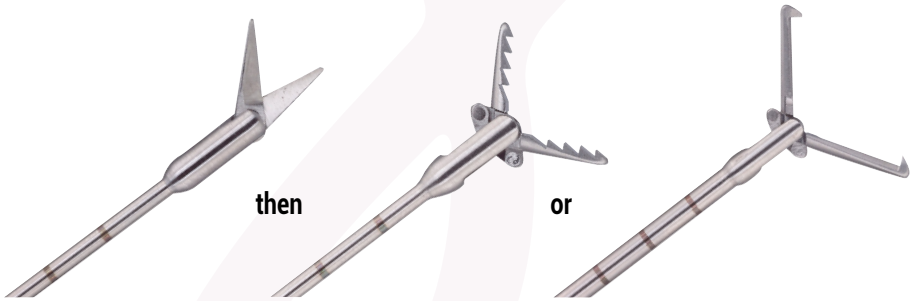
According to the slices performed, it is possible that they cannot go out through the operative channel. In this case, take them out at the same time as the hysteroscope.

Surgical technique

Slicing

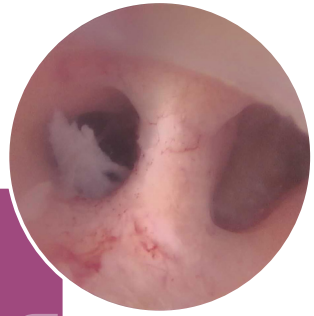
For all polyps with a volume greater than the diameter of the endocervix, it is necessary to practice the slicing technique eased by the use of 7Fr scissors.

Used instruments



In the office

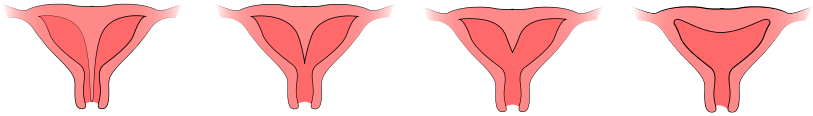
On a non-anesthetized patient, it is possible to remove all polyps of less than 15mm with the slicing technique.
The surgeon's skill acquired in the operating room under general anesthesia (GA) will enable him/her to carry out the same procedures without anesthesia in office.



The uterine septum

Definition

The uterine septum is a congenital anomaly of the female genital tract where the uterine cavity is divided by a longitudinal wall composed of fibrous and/or muscular tissues. According to the importance of the septum, we are talking about:



Total septum *Subtotal septum* *Partial septum* *Arcuate*

They are responsible for 40% of early miscarriages, fetal malposition's source of caesarean sections and premature deliveries in case of association with a cervical incompetence diagnosed by cervical ultrasound, between 16 and 20 weeks of amenorrhea.
The link between infertility and uterine septum is not proven.

Treatment

To diagnose uterine septum, carry out a 3D ultrasound with coronal view to differentiate with a bicornuate uterus and visualize the fundic serosa (serous membrane). A section of the septum must be easily performed by operative hysteroscopy.

Surgical technique

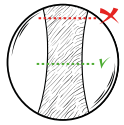
According to the operator's experience, the section is carried out either with a cold instrument like Easycare limiting the rate of synechia or with a bipolar knife settled up on a 6mm resectoscope like Resecare.

Used instrument

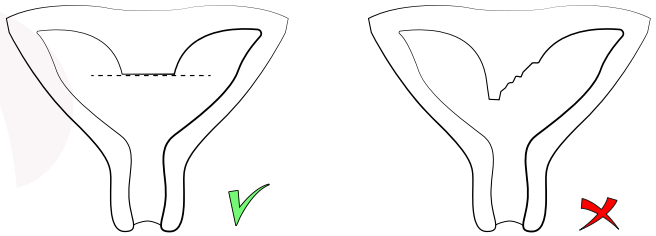
Surgical method

- **Always place the non-removable blade on the uterine wall side and not on the septum's.**
- **In case of a total partition, the use of ultrasound is compulsory.**

1. Position the hysteroscope at the low base of the septum.
2. Insert the scissors and cut the septum in its middle step by step.



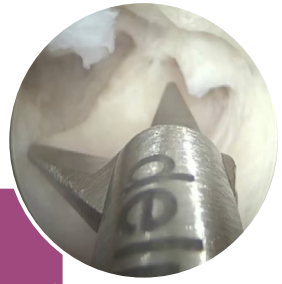
3. The deeper you cut, the wider the septum will be. It is thus necessary to shift regularly from one uterine compartment to the other to have always the bottom of the uterine cavity aligned.



4. The purpose is to have the two tubal ostia aligned at the end of the procedure. If bleeding appears, it is advised to stop the surgery. This might be due to the junction between fibrous and muscular nature of the septum. The latter does not always need to be cut.
5. Two months after the surgery, an echosonography check is necessary to eliminate a synechia and measure the size of any residue of septum (usually <10mm).

In the office

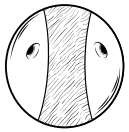
On a non-anesthetized patient, it is possible to perform the treatment of the partial and arcuate septums. The operating method is identical.
On average, only three minutes are required to remove 10mm of septum.



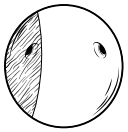
The synechia

Definition

A synechia is an adhesive process that affects the uterine corpus. It can be more or less wide. The pragmatic approach to classification presented below allows them to be categorized:



Grade I
Thin adhesions with both ostia visible.
Easily ruptured by hysteroscope sheath alone. Cornual areas normal.



Grade IIa
Singular dense adhesion blocking the tubal orifice.
Connecting separate areas of the uterine cavity. Cannot be ruptured by hysteroscope sheath alone.

Grade IIb
Multiple dense adhesions.
Connecting separate areas of the uterine cavity. Unilateral obliteration of ostial areas of the tube.

Grade III
Dense and extensive adhesions with partial obliteration of the uterine cavity.
Bilateral (partial) obliteration of the tubal ostial area.

Grade IV
Extensive endometrial scarring and fibrosis.
With amenorrhea.

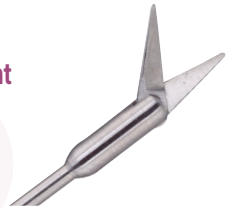
Treatment

Prevention, based on limitation or elimination of curettage is the best way to avoid synechia (prefer hysteroscopy for the treatment of trophoblastic retentions). If they interfere in the reproductive process or are symptomatic (hypomenorrhea, amenorrhea, cyclic pain), synechiae should be treated.

Surgical technique

The use of cold instruments to treat synechiae is essential because the use of energy could destroy the remaining small endometrial parts, which stimulate the regrowth of the endometrium for a better restitution of the cavity.

Used instrument



Surgical method

In the case of Type I and IIa synechiae, their removal only requires a few operatory actions. In the case of thick synechiae type IIb, III, IV, the first step is to find a safe path within the cavity until possible visualization of both ostia.

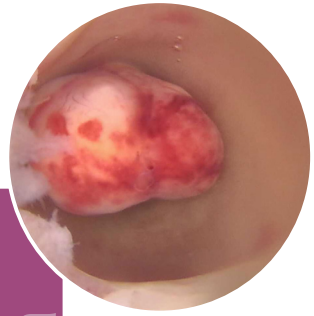
The 7Fr. scissors is more efficient and thus, of great assistance: it allows to regain a normal cavity during the first operative period.

The scissors, having larger blades, also allows to perform an act which is limited with 5Fr scissors: cutting while sliding the scissors held opened. We thus have a better handling of the instrument.

- **It is essential to use ultrasonic assistance in the case of III and IV synechiae.**
- **Always place the non-removable blade against the uterine wall and not the opposite.**

In the office

On a non-anesthetized patient, it is possible to treat type I and IIa synechiae.

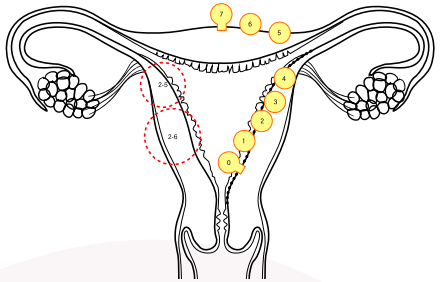


The myoma

Definition

Uterine fibroids are benign muscle tumors of the uterus. Their size can vary from a few millimeters to several centimeters. According to their position, myoma are classified by type ranking from 0 to 7.

Myoma can cause abnormal bleedings, pains but also interfere with fertility for those located in the uterine cavity.



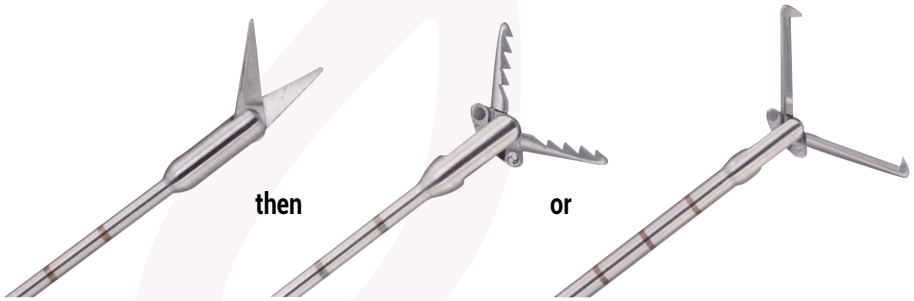
Treatment

Only symptomatic submucous myomas are treated by hysteroscopy (type 0 to 2), if they do not exceed 50mm, with a posterior safety wall greater than 5mm or under ultrasonic control if ≤5mm.

Surgical technique

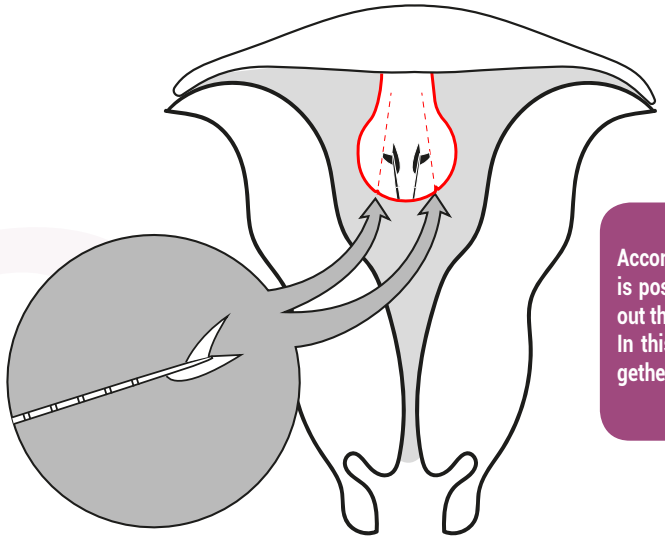
A myomectomy with EasyCare should be considered in the case of type 0 myoma of less than 20mm.

Used instruments



Surgical method

Slicing, also used for polypectomy, is the surgical method used.



According to the slices cut, it is possible that they cannot go out through the operative canal. In this case, take them out together with the hysteroscope.

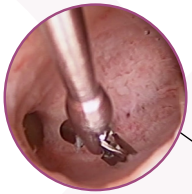
In the office

On a non-anesthetized patient, it is possible to treat type 0 myomas of less than 15mm with the slicing technique.

OPPIUM is a 2-steps technique proposed by Pr. Bettocchi. The first step is performed in the office. An incision of the endometrium along its reflective zone on the myoma is done with an operating sheath equipped with scissors. This operating action is performed at the same time as the diagnostic hysteroscopy, according to the principle of «See&Treat».

The second step is performed in the operating room two months later. During this interval, type 1 or 2 myomas are reduced to types 1 and 0 in 93% of cases, thus facilitating resection with ReseCare.

Other applications

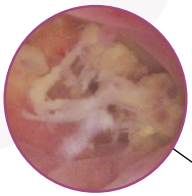


Targeted biopsy

Biopsies are performed in case of suspicion of endometrial cancer or for a diagnosis of infertility. However, depending on the method, results are different:

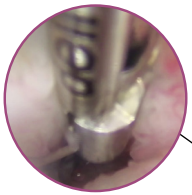
- Targeted biopsy ➡ 90% good results.
- Biopsy with the Pipelle de Cornier ➡ not more than 50%.
- Biopsy curettage ➡ not more than 50% and significant risk of synechiae.

The Plus: the 7Fr. biopsy forceps. It allows collecting a significantly larger volume of material providing thus an easier diagnosis.



Trophoblastic retention

This is the persistence of abnormal tissue within the uterine cavity following a miscarriage or sometimes even a childbirth responsible of bleeding at least one month after the initial event.
The tissue is recovered with a 7Fr. grasping forceps whose grip is more efficient.
Due to the risk of synechia, curettage is not recommended.



IUD removal

In case the IUD wire is no longer visible and therefore impossible to remove directly, hysteroscopy is the right solution. The IUD can be visualized in the uterine cavity and caught with the Pozzi or the grasping forceps. Here again, a 7Fr. forceps is more efficient.

Booklet written in collaboration with Prof. Hervé Fernandez

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