







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

Juan Diego Villegas-Echeverri^{1,2}  | Rachel Pope³  | Magali Robert⁴  |
Ivo Meinhold-Heerlein^{5,6}  | Sergio Haimovich⁷  | José Carugno⁸  |
Luis A. Pacheco⁹  | Attilio Di Spiezio Sardo^{9,10} 

¹Division of Benign Surgery, FIGO, London, UK

²ALGIA Unidad de Laparoscopia Ginecológica Avanzada y Dolor Pélvico, Pereira, Colombia

³Committee on Obstetric Fistula, FIGO, London, UK

⁴Department of Obstetrics and Gynecology, Cumming School of Medicine, Calgary, Canada

⁵Committee on Minimal Access Surgery, FIGO, London, UK

⁶Department of Gynecology and Obstetrics, University Hospital Gießen, Justus Liebig University Gießen, Giessen, Germany

⁷Department of Gynecology, Adelson School of Medicine, Ariel University, Ariel, Israel

⁸Obstetrics, Gynecology and Reproductive Sciences Department, Minimally Invasive Gynecology Division, University of Miami, Miami, Florida, USA

⁹Hysteroscopy Unit, Hospital Quirón Salud, Málaga, Spain

¹⁰Department of Obstetrics and Gynecology, University Federico II, Naples, Italy

Correspondence

Ivo Meinhold-Heerlein, Department of Gynecology and Obstetrics, University Hospital Gießen, Justus Liebig University Gießen, Giessen, Germany.

Email: ivo.meinhold-heerlein@gyn.med.uni-giessen.de

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

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial](https://creativecommons.org/licenses/by-nc/4.0/) License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.

© 2024 The Author(s). *International Journal of Gynecology & Obstetrics* published by John Wiley & Sons Ltd on behalf of International Federation of Gynecology and Obstetrics.

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.

ORCID

Juan Diego Villegas-Echeverri  <https://orcid.org/0000-0002-1903-1160>

Rachel Pope  <https://orcid.org/0000-0002-1097-7611>

Magali Robert  <https://orcid.org/0000-0001-5429-9843>

Ivo Meinhold-Heerlein  <https://orcid.org/0000-0002-0331-8781>

Sergio Haimovich  <https://orcid.org/0000-0002-9476-628X>

José Carugno  <https://orcid.org/0000-0002-5716-4933>

Luis A. Pacheco  <https://orcid.org/0000-0002-8521-3675>

Attilio Di Spiezio Sardo  <https://orcid.org/0000-0001-6485-5735>

REFERENCES

1. Norment WB, Sikes CH, Berry FX, Bird I. Hysteroscopy. *Surg Clin North Am.* 1957;37(5):1377-1386.
2. Bettocchi S. New era of office hysteroscopy. *J Am Assoc Gynecol Laparosc.* 1996;3(4, Supplement):S4.
3. Menken FC. Endoscopy procedures and their combined application in gynecology. *J Reprod Med.* 1974;13:250.
4. Kim DH, Seong SJ, Kim MK, et al. Dilatation and curettage is more accurate than endometrial aspiration biopsy in early-stage endometrial cancer patients treated with high dose oral progestin and levonorgestrel intrauterine system. *J Gynecol Oncol.* 2017;28(1):e1. doi:10.3802/jgo.2017.28.e1
5. Barut A, Barut F, Arikan I, Harma M, Harma MI, Ozmen BU. Comparison of the histopathological diagnoses of preoperative dilatation and curettage and hysterectomy specimens. *J Obstet Gynaecol Res.* 2012;38(1):16-22. doi:10.1111/j.1447-0756.2011.01633.x
6. Epstein E, Ramirez A, Skoog L, Valentin L. Dilatation and curettage fails to detect most focal lesions in the uterine cavity in women with postmenopausal bleeding. *Acta Obstet Gynecol Scand.* 2001;80:1131-1136.
7. Emanuel MH, Wamsteker K, Lammes FB. Is dilatation and curettage obsolete for diagnosing intrauterine disorders in premenopausal patients with persistent abnormal uterine bleeding? *Acta Obstet Gynecol Scand.* 1997;76(1):65-68. doi:10.3109/00016349709047787
8. Terzic M, Aimagambetova G, Bapayeva G, et al. Pipelle endometrial sampling success rates in Kazakhstani settings: results from a prospective cohort analysis. *J Obstet Gynaecol.* 2021;30:1-6. doi:10.1080/01443615.2021.1953452
9. Benchahong S, Chanthasenanont A, Pongrojapaw D, Pattaraarchachai J, Bhamarapavatana K, Suwannarurk K. Efficacy of intrauterine lidocaine instillation in reducing pain during

- endometrial biopsy by Novak. *Pain Res Treat*. 2018;2018:9368298. doi:[10.1155/2018/9368298](https://doi.org/10.1155/2018/9368298)
10. Stovall TG, Ling FW, Morgan PL. A prospective, randomized comparison of the Pipelle endometrial sampling device with the Novak curette. *Am J Obstet Gynecol*. 1991;165(5 Pt 1):1287-1290. doi:[10.1016/0002-9378\(91\)90351-q](https://doi.org/10.1016/0002-9378(91)90351-q)
 11. Connor M. New technologies and innovations in hysteroscopy. *Best Pract Res Clin Obstet Gynaecol*. 2015;29(7):951-965. doi:[10.1016/j.bpobgyn.2015.03.012](https://doi.org/10.1016/j.bpobgyn.2015.03.012)
 12. Vitale SG, Haimovich S, Riemma G, et al. Innovations in hysteroscopic surgery: expanding the meaning of "in-office". *Minim Invasive Ther Allied Technol*. 2021;30(3):125-132. doi:[10.1080/13645706.2020.1715437](https://doi.org/10.1080/13645706.2020.1715437)
 13. Romani F, Guido M, Morciano A, et al. The use of different size-hysteroscope in office hysteroscopy: our experience. *Arch Gynecol Obstet*. 2013;288(6):1355-1359. doi:[10.1007/s00404-013-2932-7](https://doi.org/10.1007/s00404-013-2932-7)
 14. Bettocchi S, Nappi L, Ceci O, Selvaggi L. What does 'diagnostic hysteroscopy' mean today? The role of the new techniques. *Curr Opin Obstet Gynecol*. 2003;15(4):303-308. doi:[10.1097/01.gco.0000084241.09900.c8](https://doi.org/10.1097/01.gco.0000084241.09900.c8)
 15. Chiofalo B, Palmara V, Vilos GA, et al. Reproductive outcomes of infertile women undergoing "see and treat" office hysteroscopy: a retrospective observational study. *Minim Invasive Ther Allied Technol*. 2021;30(3):147-153. doi:[10.1080/13645706.2019.1705352](https://doi.org/10.1080/13645706.2019.1705352)
 16. Di Spiezio SA, Zizolfi B, Lodhi W, et al. 'See and treat' outpatient hysteroscopy with novel fibreoptic 'Alphascope'. *J Obstet Gynaecol*. 2012;32(3):298-300. doi:[10.3109/01443615.2011.645922](https://doi.org/10.3109/01443615.2011.645922)
 17. Lasmar RB, Lasmar BP. Hysteroscopic management of intrauterine benign diseases. *Minim Invasive Ther Allied Technol*. 2021;30(5):263-271. doi:[10.1080/13645706.2021.1944218](https://doi.org/10.1080/13645706.2021.1944218)
 18. Del Valle C, Solano JA, Rodríguez A, Alonso M. Pain management in outpatient hysteroscopy. *Gynecol Minim Invasive Ther*. 2016;5(4):141-147.
 19. Echeng N, Burrell D, Zaluski K. Optimizing operative hysteroscopy in the office setting: updated techniques and technology. *Topic Obs & Gynecol*. 2024;44(2):1-7.

How to cite this article: Villegas-Echeverri JD, Pope R, Robert M, et al. 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. *Int J Gynecol Obstet*. 2025;168:493-496. doi:[10.1002/ijgo.16078](https://doi.org/10.1002/ijgo.16078)