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Editorial

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Can the Office Hysteroscopy Become a Routine Screening Test?

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The endoscopic assessment of cavitary organs, with the exception of the uterus, became the gold standard for cancer screening and prevention in the 21st century. The aim of this communication is to suggest to include hysteroscopy as a part of regular well women examination. The use of colonoscopy as a primary screening tool for colorectal cancer is gaining momentum due to several studies suggesting its effectiveness [1-3]. The American Cancer Society and the American College of Gastroenterology published guidelines for colorectal cancer screening in which they recommend that screening should begin at age 50 for all asymptomatic individuals. The American Cancer Society recommends that average-risk individuals obtain a flexible sigmoidoscopy every 5 years or a colonoscopy every 10 years [1-4].

Surveillance colonoscopy represents an important component of any colon screening program and ideally should be targeted at patients at risk for colorectal cancer [5-7]. Recommendations for surveillance intervals after the removal of cancer or adenomas with high-grade dysplasia range from 1 to 3 years [8].

However, despite intense surveillance, interval cancers have been reported after negative examinations [9,10]. The overall rate of interval cancer was 1.1-2.7 per 1000 person-years of follow-up [11]. If the computerized tomography (CT) revealed a polyp and the colonoscopy did not, the region is reexamined; if a polyp (s) is found on the second look, it is considered a missed lesion by the colonoscopy. Studies suggest that that up to 17% of lesions <10 mm can be missed with the colonoscopy [12-14]. Case control and observational studies have suggested that patients who have had a colonoscopy have reduced their chance of developing colon cancer for 10 or more years [15-19]. Kani, et al., conducted a long-term follow-up study and demonstrated that in an average-risk population undergoing screening colonoscopy, the risk of colon cancer is reduced by 48% to 67%, and the risk of death from colon cancer is reduced by 65% [20]. The National Polyp Study reported that patients with adenomas who underwent a colonoscopic polypectomy experienced a 76% reduction in colorectal cancer [19,20]. Meissner, et al., reported that less than half of U.S. age-eligible adults reported receiving any of the recommended colorectal cancer screening tests [21]. Colorectal screening programs utilization rates are similar to those observed for mammography.

Screening for Endometrial Cancer

In the United States in 2015, endometrial cancer was diagnosed in 54,870 women, with 10,170 of them succumbing to the disease [22-26]. In 1989, Loffer demonstrated that a hysteroscopy with a directed biopsy was superior to a blind dilation and curettage for diagnosing the causes of abnormal uterine bleeding [27].

Kelekei, et al., compared the diagnostic accuracy of vaginal sonography (VS), saline infusion sonography (SIS), and office hysteroscopy (OHS) for detecting endometrial abnormalities in women with or without abnormal uterine bleeding [28]. The sensitivity and specificity of VS, SIS, and OHS were 56.3% and 72%, 81.3% and 100%, and 87.5% and 100%, respectively. This prospective cohort study by Soguktas, et al., involved the examination of 89 premenopausal women between the ages of 36 and 48 years, all of whom were initially imaged with VS, followed up with SIS and OHS [29]. These authors found that OHS produced the most accurate results [29].

We share our experience with using office hysteroscopy for gynecologic patients with and without showing symptoms of endometrial pathology. Our experience corroborates with one of the other investigators attesting to the high accuracy of the office hysteroscopy. In most cases, we used the Endosee Device (Cooper Surgical) and LiNa Opera Scope, both of which include a sterile, single-use flexible cannula less than 5 mm in diameter. The device consists of a camera and a light source at the distal end of the device. In 5-7% of cases, we were able to detect lesions (small polyps, areas of hyperplasia, etc.) missed during sonography. Cruz Lee, et al., provided a systemic review and meta-analysis of the oncogenic potential of endometrial polyps [30]. Seventeen studies met the inclusion criteria for their review. Among women found to have endometrial polyps, the prevalence of premalignant or malignant polyps was 5.42% (214 of 3,946) in postmenopausal women compared with 1.7% (68 of 3,997) in reproductive-aged women. The prevalence of endometrial neoplasia within polyps in women with symptomatic bleeding was 4.15% (195 of 4,697) compared with 2.16% (85 of 3,941) for those without bleeding. Among symptomatic postmenopausal women with endometrial polyps, 4.47% (88 of 1,968) had a malignant polyp in comparison to 1.51% (25 of 1,654) of asymptomatic postmenopausal women.

In conclusion, we believe that with gaining more experience with office hysteroscopy and its decreasing costs, this procedure may well become a choice for screening for endometrial pathology similar to the use of the colonoscopy for screening for bowel pathology. In view of the recent technical advances in hysteroscopy (the development of a portable office device, no need for anesthesia, acceptance by patients, low cost, no need for presurgical testing in most cases, among others), we may consider recommending the inclusion of the office hysteroscopy in routine office procedures during a well-woman exam. We realize that this suggestion may seem controversial. Consider however, how the transvaginal ultrasound, which according to the majority of investigators is inferior to the hysteroscopy, became a de-facto part of routine gynecological examinations [28,29].

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