ASRM AP3G Example Procedure Protocol

ENDOMETRIAL BIOPSY

Advanced Practice Provider Professional Group of the American Society for Reproductive Medicine

APP Education Task Force: Jamie Feingold (Chair), Melissa Peluso, Tamara Tobias, Jeanine Price, Jamie Neary, Tema Rubin, Ashley Brown, Lorrie Posegay, Michelle Bigelman, Molly McCluskey

Indications

1. Abnormal uterine bleeding
    a. Rule out endometrial hyperplasia or malignancy
    b. Assess for endometrial polyps
2. Evaluation for endometriosis or endometritis
3. Evaluation for presence of chorionic villi in setting of pregnancy of unknown location.
    a. Before performing an endometrial biopsy for the above indication, the provider should take care to review their state and practice policies.

Contraindications

1. Known presence of viable pregnancy
2. Suspicion of pelvic inflammatory disease or other vaginal infection
    a. Symptoms of cervicitis
    b. Pelvic tenderness
    c. Abnormal vaginal discharge
3. Heavy vaginal bleeding- may be very difficult to obtain a sample
    a. Spotting is acceptable
4. Possibility of pregnancy and no recent pregnancy test

Pre-procedure

1. Serum pregnancy test since first day of last menstrual period OR urine pregnancy test required on day of procedure (even in patients with no possibility of pregnancy ex TDI)
2. Patients should take 800 mg ibuprofen 1 hour prior to procedure. Acetaminophen 1000 mg is appropriate alternative in those who cannot tolerate ibuprofen.
3. Confirm no allergies to Latex or Betadine. If allergies are present, the room will be prepared with the latex-free TVUS probe cover for latex allergy, and a 2–4% chlorhexidine gluconate for alternative cervical prep for those with allergies to Betadine.
4. There are numerous indications for endometrial biopsy. The patient should understand the rationale for their procedure today as well as potential associated cost of testing

Procedure

1. Provider to review expectations, risks and alternatives and obtain verbal consent to proceed. A “time out” should be performed per practice specific policy. Pt to assume lithotomy position
2. Provider dons NON-STERILE gloves

3. Per provider preference, TVUS or bimanual exam can performed to assess orientation of uterus. Transabdominal ultrasound may be performed during the procedure if desired to guide pipelle placement.
4. Speculum is inserted and cervix visualized and prepped in the usual fashion.
    a. Lidocaine prep may be performed to aid in pain relief (see "Cervical Block SOP")
    b. For certain testing, utilization of betadine may be contraindicated, as it may alter testing results. In these cases the cervix should be swabbed with a clean scolpette and sterile water if needed.
5. Biopsy pipelle is inserted into the uterine cavity using steady and gentle pressure. A slight bend at the tip of the pipelle may ease passage through the cervical canal. Utilizing the demarcations on the pipelle, the provider should take care to note the depth of the uterine cavity. If the pipelle is less than 6 cm in to the cavity, the tip is likely still in the endocervical canal. If the pipelle is more than 9 mm, the provider may be too far in to the cavity and could have punctured the myometrium.
    a. If pipelle will not pass through cervical canal, tenaculum may be applied to create traction
6. The specimen should be obtained. Typically, the inner sheath of the biopsy pipelle is withdrawn, leaving the external sheath within the cavity. This negative pressure creates gentle suction, which, when combined with gentle scraping of the endometrium using a back and forth motion, allows endometrial tissue to be extracted from the lining and collected within the lumen of the pipelle. The pipelle should be rotated within the cavity to obtain a comprehensive sample.
7. Once the provider suspects an appropriate amount of tissue has been extracted, the entire pipelle is withdrawn and the specimen ejected from the lumen of the pipelle in to the appropriate collection container.
8. If the sample appears inadequate, the above procedure may be repeated as needed. If more than 3 passes are needed, it is our suggestion that a second provider attempts the procedure and trans abdominal ultrasound guidance utilized.
9. Prior to leaving the room, the specimen is labeled with appropriate patient information

Post-Procedure

1. After the procedure is complete, the patient may sit up, or remain supine for additional discussion of the results. Should symptoms of a vasovagal reaction occur (ex. nausea, dizziness, flushing), return the patient to supine and symptoms will typically resolve with time, cool pack, and juice/crackers.

2. Patient will be provided with a sanitary pad/wash cloth and post-procedure instructions, including expectations for bleeding/pain management and to minimize infection risks. Mild cramping is expected and may be managed with NSAIDs. Spotting is also normal.

    a. Avoid intercourse/tampons/douching for 24 hours. These recommendations may vary. Please refer to practice guidelines.

b. Call with the following:
    i. Heavy bleeding
    ii. Severe abdominal pain
    iii. Fever/chills
    iv. Abnormal vaginal discharge

3. Provider reviews plan for next steps briefly with patient.
4. Patient advised to reach out to their care team with any additional questions or concerns

References

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