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IS THERE A ROLE FOR A FLEXIBLE CYSTOSCOPY SERVICE IN A UROGYNAECOLOGY SETTING?

Hypothesis / aims of study
There has been considerable expansion in the use of flexible cystoscopy. The aim of this study was to evaluate the role of a flexible cystoscopy service within a urogynaecology service.
Study design, materials and methods
A retrospective analysis of 127 consecutive women who were referred for a flexible cystoscopy over a 15 month period (Nov 2008- Mar 2010). All procedures were carried out in the urogynaecology clinic using a CST-5000 Flexible Video Cystoscope (Vision Sciences; Natick, MA, USA) using the sterile single-use slide-on™ disposable endosheath endoscope system (EndoSheath®; Vision Sciences) under local anaesthesia using instillagel. Bladder mucosa biopsies taken as indicated.

All patients had their urine tested for nitrites prior to cystoscopy. If this was positive then the procedure was deferred after patients' had completed a course of antibiotic treatment. Patients were advised to report symptoms of urinary tract infection, pain or haematuria subsequent to the period.

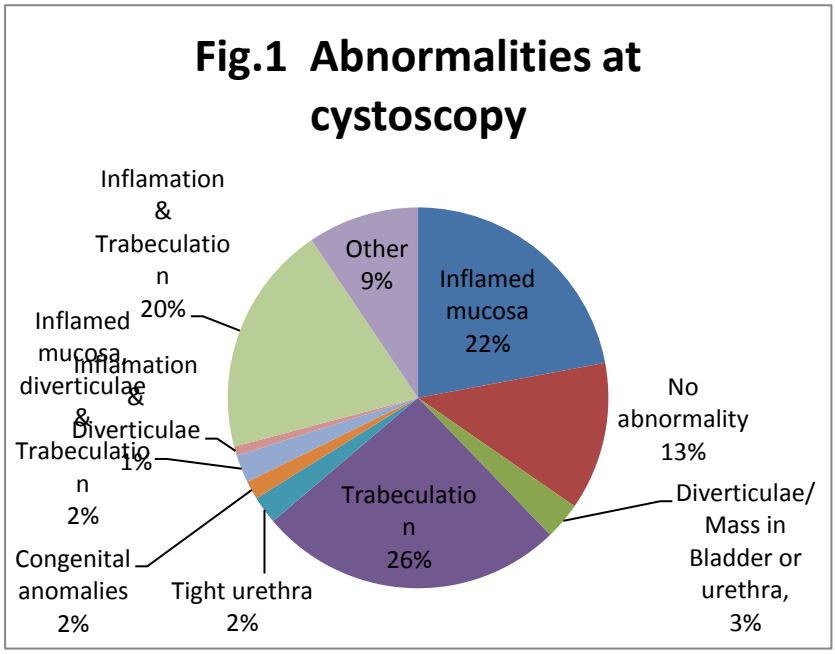
Results
Majority of women (120/127; 94.5%) successfully underwent a flexible cystoscopy. Two patients did not attend clinic (2/127; 1.6%), two were deferred due to positive nitrites and a further two did not require the test as they had had a flexible or rigid cystoscopy elsewhere. One patient declined to have the procedure.

The mean age was 48.6 years (range 20–88 years). Seven women (7/127; 5.5%) were nulliparous and the range of BMI was 18-42.

Indications for referral were as follows:		n	%
Detrusor overactivity (DO) not responding to 2 or more anticholinergics	34	26.8	
Recurrent urinary tract infections	37	29.1	
Recurrent urinary tract infections & DO		47	37.0
Bladder or suprapubic pain or persistent dysuria		6	4.7
Periurethral swellings		2	1.6
Haematuria		1	0.8

Eighteen percent of patients had a mesh of some description inserted in the past (23/127).

Majority of women (117/120; 97.5%) had some abnormality detected at cystoscopy. The findings at cystoscopy were as illustrated below:



One patient had a urethral dilatation under local anaesthesia. A total of 32 patients had a biopsy of the bladder mucosa (32/120; 26.7%). Majority of these confirmed histological diagnosis of chronic inflammation (28/32; 88%) with one case of atypia and one case of interstitial cystitis. No abnormality was detected in two cases (2/32; 6%). No cases of bladder tumours were detected. Three patients were subsequently referred for further urological assessment (3/120; 2.5%).

More than 95% of women reported no significant discomfort with the flexible cystoscopy. No reported cases of UTIs or clot retention from biopsies. Mild to moderate haematuria was noted in most case of biopsies but this settled spontaneously within 72 hours.

Interpretation of results

The data suggest that patient selection for non suspicious indications in a urogynaecology has its merits with high detection rates of abnormalities. The low incidence of significant pathology on biopsy reflects the low risk population for bladder tumours but may also be a reflection of the relatively small sample size. The diagnosis on biopsy of inflammation of bladder mucosa then justifies the long term antibiotic therapy that would follow such cases especially in recurrent UTIs and detrusor overactivity not responding to conventional therapy. The low complication rates illustrate the benefits of outpatient flexible cystoscopy including high levels of tolerability and shorter waiting time including the need to institute treatment. The value of moving to an ambulatory setting excluding theatre and anaesthetic costs makes this more effective way managing these patients especially in the current financial climate.

Concluding message

This retrospective analysis of current practice in our institution with careful patient selection and appropriate referral criteria highlights clear a role for the use of flexible cystoscopy in a urogynaecology setting which assists in establishing a definitive diagnosis with low operative morbidity.

Specify source of funding or grant	**NONE**
Is this a clinical trial?	**No**
What were the subjects in the study?	**HUMAN**
Was this study approved by an ethics committee?	**No**
This study did not require ethics committee approval because	**THIS WAS A RETROSPECTIVE ANALYSIS OF CURRENT CLINICAL PRACTICE.**
Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**Yes**