

Dilatation and Curettage (D&C)

Policy

This policy should be read in conjunction with the “Hysterectomy for Menorrhagia” policy

Dilatation and curettage is routinely funded for ERPC and evacuation of molar pregnancies.

Hysteroscopy and biopsy is the treatment of choice for:

- Investigation and/or treatment of menorrhagia (HMB) – NICE CG no.44
- Investigation of dysfunctional uterine bleeding (DUB) or post-menopausal bleeding (PMB)
- Treatment of irregular periods
- Treatment of endometrial hyperplasia
- Removing unwanted tissue, endometrial polyps or benign tumours from the womb

These policies have been approved by the eight Clinical Commissioning Groups in North West London (NHS Brent CCG, NHS Central London CCG, NHS Ealing CCG, NHS Hammersmith and Fulham CCG, NHS Harrow CCG, NHS Hillingdon CCG, NHS Hounslow CCG and NHS West London CCG).

Background

Dilatation and curettage (D&C) is a procedure performed under general anaesthetic in which the lining of the uterus (the endometrium) is blindly biopsied (diagnostic) or removed (therapeutic) by scraping with a sharp metal instrument (curette) in a systematic fashion.

Historically, D&C was the traditional diagnostic technique for obtaining endometrial samples for pathological examination (detecting histological abnormalities), e.g. in investigation of menorrhagia/heavy menstrual bleeding (HMB), dysfunctional uterine bleeding (DUB), or post-menopausal bleeding (PMB). However, as the technique is ‘blind’, the operator cannot assess whether lesions have been missed. In several small case series, where patients had a D&C immediately prior to hysterectomy for PMB, endometrial lesions were overlooked in up to 10% of the instances in which D&C was the only procedure used¹. One study evaluating the completeness of endometrial sampling by D&C showed that in 60% of patients less than half the cavity was curetted¹.

Ultrasound is the recommended first-line investigation to detect structural abnormalities in investigation of HMB or PMB². Hysteroscopy (allows direct visualisation of the uterine cavity) should be used as a diagnostic tool only when ultrasound results are inconclusive². Neither saline infusion sonography nor MRI should be used as a first-line diagnostic tool². To *detect* histological abnormalities in HMB (i.e. to exclude endometrial cancer or atypical endometrial hyperplasia), endometrial sampling or hysteroscopy with directed biopsy (curettage) have superseded D&C for obtaining endometrial tissue. Indications for an endometrial biopsy/sampling in investigation of HMB include persistent inter-menstrual bleeding, and in women aged ≥ 45 years - treatment failure or ineffective treatment². D&C is no longer recommended as a diagnostic tool for HMB².

Background (continued)

D&C has also been used historically for *treatment* purposes, e.g. where first line (medical) therapy has been ineffective in management of menorrhagia/ heavy menstrual bleeding (HMB), irregular periods or endometrial hyperplasia; or for evacuation of retained products of conception, removal of molar pregnancy (gestational trophoblastic disease), removal of unwanted tissue, endometrial polyps or benign tumours from the womb.

Limited evidence is available on the use of therapeutic D&C for heavy menstrual bleeding, but the one study that was identified showed that any effect was temporary². Given the limited evidence, the NICE recommendation – that D&C should not be used as a therapeutic treatment for HMB – was based on clinical experience². While medical treatment options remain first-line, surgical treatment options for HMB and DUB include endometrial ablation methods that preserve the uterus but ‘ablate’ (remove) the lining (these have superseded D&C); and hysterectomy (the definitive treatment, which results in high satisfaction rates but with potential surgical morbidity)²⁻⁴. The first generation gold standard hysteroscopic ablative techniques include laser, transcervical resection of the endometrium and rollerball⁵. Where dilatation is required for non- hysteroscopic (‘blind’) (second generation) ablative procedures, NICE recommend that hysteroscopy should be used immediately prior to the procedure to ensure correct placement of the device².

Evacuation of retained products of conception (ERPC) after incomplete miscarriage or delivery has been recommended treatment in order to reduce potential complications like blood loss and infection⁶. Surgical evacuation has been considered the most effective method of ensuring complete evacuation, by D&C (sharp metal curettage) historically, or by vacuum aspiration/suction curettage. A 2001 Cochrane review of trials⁷ found that vacuum aspiration/suction curettage was safe, quick and easy to perform, and less painful than D&C, and in most developed countries vacuum aspiration has replaced D&C for surgical evacuation of the uterus in management of incomplete miscarriage⁵. A 2006 Cochrane review⁶, and the large randomized controlled MIST trial⁸ also suggest however, that non-surgical treatments including expectant (watchful waiting) and medical management are reasonable alternatives to routine surgical uterine evacuation depending on the clinical situation and the patient's desires⁹.

Gestational trophoblastic disease encompasses a range of pregnancy-related disorders, consisting of the premalignant disorders of complete and partial hydatidiform mole, and the malignant disorders of invasive mole, choriocarcinoma, and the rare placental-site trophoblastic tumour¹⁰. Suction/vacuum curettage (rather than sharp metal curettage/D&C) is the preferred method of evacuation irrespective of uterine size in patients with suspected hydatidiform mole who want to preserve fertility. Intraoperative ultrasonography can reduce the risk of uterine perforation¹⁰. Hysterectomy is rarely recommended but might be considered for women who do not want further children or have life-threatening haemorrhage¹⁰. Hysteroscopy and biopsy (curettage) is the preferred technique to detect polyps and other benign lesions, and allows targeted removal.

References

Patient information

Dilatation and Curettage: [http://www.nhs.uk/conditions/dilatation-and-curettage-\(dc\)/Pages/Introduction.aspx](http://www.nhs.uk/conditions/dilatation-and-curettage-(dc)/Pages/Introduction.aspx)

Menorrhagia:

<http://www.nhs.uk/conditions/periods-heavy>

References

1. Investigation of Post-Menopausal Bleeding. SIGN Publication No 61; 2002.
2. National Institute for Health and Clinical Excellence. Heavy menstrual bleeding. Clinical guideline 44. 2007.

References (continued)

3. Apgar BS, Kaufman AH, George-Nwogu U, Kittendorf A. Treatment of menorrhagia. *Am Fam Physician*. 2007 Jun 15;75(12):1813-9.
4. Duckitt K, Collins S. Menorrhagia. *Clin Evid (Online)*. 2008; 2008.
5. Lethaby A, Hickey M, Garry R, Penninx J. Endometrial resection / ablation techniques for heavy menstrual bleeding. *Cochrane Database Syst Rev*. 2009(4):CD001501.
6. Nanda K, Pelligia A, Grimes D, Lopez L, Nanda G. Expectant care versus surgical treatment for miscarriage. *Cochrane Database Syst Rev*. 2006(2):CD003518.
7. Forna F, Gulmezoglu AM. Surgical procedures to evacuate incomplete abortion. *Cochrane Database Syst Rev*. 2001(1):CD001993.
8. Trinder J, Brocklehurst P, Porter R, Read M, Vyas S, Smith L. Management of miscarriage: expectant, medical, or surgical? Results of randomised controlled trial (miscarriage treatment (MIST) trial). *BMJ*. 2006 May 27;332(7552):1235-40.
9. Chen BA, Creinin MD. Contemporary management of early pregnancy failure. *Clin Obstet Gynecol*. 2007 Mar;50(1):67-88.
10. Seckl MJ, Sebire NJ, Berkowitz RS. Gestational trophoblastic disease. *Lancet*. 2010 Jul 28.