BOSTON IVF

CONSENT FORM FOR AN ENDOMETRIAL BIOPSY

An endometrial biopsy is a procedure that involves the removal of endometrial tissue from the uterine cavity for examination. The endometrial biopsy can be performed as part of an infertility evaluation to assess the adequacy of the uterine lining, which is influenced by progesterone levels in the blood. In addition, women who have a history of abnormal bleeding, irregular or absent menstrual periods, or have had a previous endometrial biopsy demonstrating the presence of infection, may benefit from the performance of an endometrial biopsy.

PROCEDURE

The procedure is performed in the office. First, a speculum is placed in the vagina to visualize the cervix. A small plastic catheter is then inserted into the cervical canal and into the uterine cavity. In some cases, it may be necessary to attach an instrument to the cervix to help pass the biopsy catheter into the uterine cavity. After the catheter is inserted, a biopsy of the endometrium is aspirated into the catheter, which is then removed. In most cases, the biopsy is completed within 4-5 minutes. This procedure can be associated with some lower abdominal cramping which will subside after the biopsy is completed. The endometrial biopsy is then sent to the laboratory for an examination by a pathologist. Results of the biopsy are available approximately one week after it is performed.

COMPLICATIONS

Complications following this procedure are uncommon. Some of the complications include the following:

1. **Pelvic infection** - The performance of this test can result in an infection that could produce lower abdominal pain and fever that develop within a few days following completion of the procedure. A consequence of this infection may be scarred fallopian tubes and infertility. If an infection develops, hospitalization with IV antibiotics and surgery may be indicated.
2. **Exposure of potential pregnancy** – If your last menstrual period was not normal or there is a possibility that you could be pregnant please request that a pregnancy test be performed before the procedure. However, if the pregnancy is too early the pregnancy test may be negative. If the endometrial biopsy is performed during an early pregnancy there is a possibility that the performance of the biopsy could increase the chance of a miscarriage.
3. **Uterine Perforation**- An uncommon complication of this procedure is uterine perforation. If this occurs, the procedure is stopped. Perforation can result in injury to other organs including the intestines, bladder, uterus and blood vessels. Injury to these organs could result in a hospitalization and additional treatment that could include surgery to repair the injury.

INSTRUCTIONS FOLLOWING THE TEST

Following the completion of the test, you can return to your normal routine. If you develop any fever, chills, severe abdominal pain or heavy vaginal bleeding, you should contact the physician immediately. If you should have any difficulty in contacting your physician you should proceed to the emergency department of the nearest hospital.

ACKNOWLEDGEMENT OF INFORMED CONSENT

I acknowledge that I have read and understand this written material. I understand the purpose, risks and benefits of this procedure. I am aware that there may be other risks and complications not discussed that may occur. I also understand that during the course of the procedure, unforeseen conditions may be revealed requiring the performance of additional procedures. I also understand that technical problems with the instrumentation may prevent the completion of the procedure. I acknowledge that no guarantees or promises have been made to me concerning the results of this procedure or any treatment that may be required as a result of this procedure. This procedure has been explained to me in language that I understand. **I have been given the opportunity to ask questions which have been answered to my satisfaction.** I have also considered other options and alternatives**. I consent to the performance of the procedure described above**.

_________________________ Signature of Patient

_________________________ Signature of Physician

_________________________ Printed Name

_________________________ Date of Birth

_________________________ Date

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