# No longer having to simply endure

**Concrete options to prevent and relieve pain, with an informed choice for every woman.**

Gynéco sans douleur calls for pain to be anticipated, appropriate options to be explained and genuinely accessible, and every woman to be able to choose what suits her with her care team, without pressure to accept or refuse medication.

## Options exist

Depending on the procedure and situation, local anaesthesia, certain medications or sedation may be discussed. Less painful techniques can also improve care. A method that works for one procedure is not necessarily effective for another. No option guarantees complete absence of pain.

## Choice is part of care

The discussion should cover expected benefits, risks, contraindications, availability and alternatives. The person must be able to report pain, request a pause and discuss another plan if relief is inadequate.

Comfort measures can complement care if wanted. They must not automatically replace appropriate pain relief or be used to ask someone simply to endure.

## Concrete collective action

We want pain relief to be part of care, not something people must find the courage to request. This initiative also seeks realistic organization for teams and equitable access to care.

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General information and a citizen perspective. This document is neither a care protocol nor a professional clinical validation. Historical dossier pages are retained after this supplement. English translation of the French update; no new clinical review.



English translation. Clinical, legal and educational reviews pending.

# What the studies show

## IUD placement: local anaesthesia may help

A 2018 randomized trial involving 64 women who had never given birth found median insertion pain of 33/100 with a paracervical block, versus 54/100 without a paracervical block (sham procedure). Both groups received a small amount of anaesthetic at the tenaculum site. The injection itself can be painful. This result does not guarantee the same benefit for everyone. [1]

## Endometrial biopsy: an option in outpatient care

A 2022 trial involving 123 participants studied a paracervical block with a one- or three-minute wait. Pain control was better than in the comparator groups studied. This is relevant to feasibility, not proof of savings or of no effect on access delays. [2]

## Hysteroscopy: technique matters too

A review of seven trials published in 2020 found that vaginoscopy, performed without a speculum or tenaculum in appropriate situations, reduced average pain, procedure duration and vasovagal episodes compared with the comparator technique. It does not remove the need to discuss pain relief. [3]

Another 2020 meta-analysis found an average reduction in pain with local anaesthesia during hysteroscopy. The protocols studied were heterogeneous. [4]

## Gas: procedure-specific findings

A 2026 trial in office operative hysteroscopy found less pain with nitrous oxide. This does not prove its effectiveness for all gynaecological care or its cost-effectiveness in Québec. Equipment, training and monitoring matter. [5]

Targeted, non-exhaustive research among publications from the past ten years. Recent reviews may include older trials. Average effect, satisfaction and technical success are different outcomes. No self-medication dosages are proposed.



English translation. Clinical, legal and educational reviews pending.

# Relieving pain while preserving access to care

## Must we choose between relieving one patient’s pain and seeing the next patients?

Pressure on appointments and resources is real. But presenting pain relief and access as systematically incompatible does not reflect all the options. Some improvements in technique or organization may support both goals. This must be evaluated, not assumed.

## Concrete options without excessive promises

**Adapt the technique:** the vaginoscopy review found both less pain and shorter procedures. It did not directly measure waiting times or cancer diagnoses. [3]

**Offer options in clinic:** local blocks can be considered for some procedures without routinely using general anaesthesia. They nevertheless require skills, equipment and the ability to manage adverse effects. [1, 2, 4]

**Arrange another option when necessary:** some people or procedures warrant more time, sedation or another care setting. The least expensive option must not be imposed at the expense of consent or safety.

## What we cannot claim

The selected studies do not show that better pain relief will never affect waiting times or that the number of cancer diagnoses will remain identical. Nor do they allow savings for Québec to be quantified. An economic review favours the outpatient setting for certain costs, but also reports more postoperative pain: savings alone are not a sufficient indicator. [6]

## Measure the whole care journey

A pilot project could jointly track pain, adverse effects, choice and sense of control, interrupted or repeated procedures, total time, recovery, access delays and costs. This evaluation proposal is an organizational possibility, not a study finding.

**Our position:** improving access to care and providing appropriate pain relief are two goals to pursue together. Savings must not depend on an obligation to endure.



English translation. Clinical, legal and educational reviews pending.

# Elsewhere: documented options

## Switzerland: a hospital example

Geneva University Hospitals state that some diagnostic hysteroscopies can be performed with MEOPA, an oxygen and nitrous oxide mixture with analgesic and anxiolytic effects. This documented service does not represent all Swiss practice.

Source: HUG, patient information on diagnostic hysteroscopy

## United Kingdom: choice of care setting

The RCOG describes the option of hysteroscopy under general or regional anaesthesia, or sedation, in a setting other than the outpatient clinic. It also notes that patients can ask for the procedure to stop. Professional information does not prove uniform access everywhere.

Source: RCOG, Outpatient hysteroscopy

## United States: an individualized plan

The 2025 ACOG consensus recommends individualized discussion of options for office cervical and uterine procedures. It is distinct from a clinical trial and does not guarantee availability of every option.

Source: ACOG, Clinical Consensus No. 9 (2025)

## What we propose for Québec

Draw on these options, adapt them to local resources and skills, and jointly measure pain, safety and access. This does not mean that none of these options exist in Québec, nor does it promise zero pain or no effect on waiting times.

Institutional examples accessed November 13, 2026. They complement the studies without replacing professional clinical validation.



English translation. Clinical, legal and educational reviews pending.

# Sources and scope of the update

**[1] Mody et al. (2018). Paracervical Block for Intrauterine Device Placement Among Nulliparous Women. Randomized trial.**
https://pubmed.ncbi.nlm.nih.gov/30095776/

**[2] Effectiveness of paracervical block in endometrial sampling procedures (2022). Randomized trial.**
https://pubmed.ncbi.nlm.nih.gov/35894487/

**[3] De Silva et al. (2020). Vaginoscopy for office hysteroscopy. Systematic review and meta-analysis.**
https://pubmed.ncbi.nlm.nih.gov/32645643/

**[4] De Silva et al. (2020). Local anaesthesia for office hysteroscopy. Systematic review and meta-analysis.**
https://doi.org/10.1016/j.ejogrb.2020.05.062

**[5] Nitrous Oxide for Pain Management in Office Hysteroscopy (2026). Randomized trial.**
https://pubmed.ncbi.nlm.nih.gov/41955620/

**[6] Bennett et al. (2019). Effectiveness of Outpatient Versus Operating Room Hysteroscopy. Systematic review and meta-analysis.**
https://pubmed.ncbi.nlm.nih.gov/30528838/

## Additional professional recommendation

ACOG, Clinical Consensus No. 9 (2025): discussion of pain-management options for office cervical and uterine procedures. This consensus is distinct from the trials above.

https://pubmed.ncbi.nlm.nih.gov/40373312/

Scope: supplement added to the two general dossiers. Previously sent documents are not automatically resent. Resources for other care pathways and the toolkits do not become clinically validated protocols through this addition.



English translation. Clinical, legal and educational reviews pending.