Outpatient Cystoscopy SOP

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1.0 Introduction

Outpatient cystoscopy is an alternative to inpatient cystoscopy for patients who are judged clinically to be suitable for outpatient cystoscopy and are happy to have the procedure. This document outlines guidance for outpatient cystoscopy indications, set-up and pre and post procedural care for this procedure.

Patients referred to the Outpatient Cystoscopy Clinic should be sent the Outpatient Cystoscopy Clinic Patient Information Leaflet Appendix 2 and possibly Appendix 3 if Botox is on the TCI card with the appointment letter.

Outpatient cystoscopy avoids the need for anaesthesia, with its potential complications. It helps patients recover better as they go home straight after the procedure and take less time off. It spares them the need to attend the pre-operative assessment clinic, have investigations, including blood tests, and fast prior to admission.

The following types of cystoscopy can be carried out in the outpatient setting:

- Diagnostic Cystoscopy
- Diagnostic cystoscopy and bladder wall biopsy
- Cystoscopy and Botox bladder wall injection (for the purpose of this SOP the Botulinum Toxin A in reference is Botox)
- Urethral bulking agent injection under cystoscopy guidance

It is important to ensure that the patient is comfortable under all circumstances and that the procedure is safe. The use of analgesia and local anaesthesia before outpatient cystoscopy should be discussed and organised for on booking the outpatient cystoscopy.

Infection control measures should be applied, to reduce the risk of urinary tract infection.

2.0 Scope

This SOP applies to the following:

- Gynaecology nurses
- Gynaecologists

3.0 Responsibilities

Gynaecology nurses and gynaecologists:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this guideline.

Management:

- To ensure the guideline is reviewed as required in line with Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

4.0 Definitions and abbreviations used within this SOP

EPMA Electronic Prescribing and Medicines Administration	**U** units
MDM Multi-Disciplinary Team Meeting	**mg** Milligrams
ml Millilitres	**UPT** Urinary Pregnancy Test
SOP Standard Operating Procedure	

5.0 Recommendations

The trolley to be used for outpatient cystoscopy should be cleaned with cleaning wipes, using gloves.

The following will be required:

- Sterile catheterisation pack
- Cystoscope sheath and plastic bag
- Normal Saline
- Sterile gauze swabs or cotton balls
- 3 pairs of sterile gloves
- Sterile intravenous giving set
- 500ml bag of sodium chloride 0.9%. A glycine bag may be required when biopsy is likely, as diathermy may be used, depending on the preference of the operator
- A sterile receiver
- An in/out urethral catheter
- Instillagel
- A drape with a collection pocket may be used for longer procedures, such as Botox bladder wall injection and urethral bulking agent injection.

5.1 Preparing the cystoscope

- After putting on an apron, hands should be washed and dried before sterile gloves are put on.
- The cystoscope sheath should be placed in the sheath holder on the workstation.
- The scope should be carefully fed into the sheath until it engages with the optical lens.
- The scope cover should be pulled over the working piece of the scope and engaged with the eyehole.
- The view should be checked to ensure that a good view can be obtained through the scope. If the view is suboptimal, then realigning the sheath with the optical

lens may need to be carried out. If this is unsuccessful, then sheathing may need to be re-done with a new sheath.

- The sodium chloride 0.9% bag should be removed from its cover and connected to the intravenous giving set, without desterilising the intravenous giving set part to be connected to the cystoscope.
- The light source and intravenous giving set should be connected by an assistant.

5.2 Preparing the local anaesthesia

- For Bulkamid urethral bulking agent injection, Instillagel and paraurethral injection using 2% Lignocaine 10ml (need to be prescribed) via syringe and blue needle at 3 and 9 o'clock.
- For diagnostic cystoscopy and Botox, Instill local anaesthetic lubricant gel into urethra.

5.3 Preparing the patient

- Introductions should be made, and the procedure explained again. Consent should be checked and confirmed.
- All patients should have urinalysis and UPT performed. If urine positive for leucocytes, nitrites and blood, the consultant will review and decide to proceed or defer. Refer to Bulkamid Proforma Appendix 1. If positive UPT - Defer BOTOX and clinician should have a discussion with patient regarding diagnostic cystoscopy and Bulkamid.
- There is no current routine consensus on use and choice of prophylactic antibiotic and this should be assessed and decided based on patient factors and clinician discretion.
- The vulval area, and urethra, should be cleaned with normal saline.
- Instillagel (lubricating jelly with local anaesthestic) should be injected into the urethra.
- After allowing time for the local anaesthetic to work, a sterile in/out catheter should be used to empty the bladder into the receiver.

5.4 Performing the Flexi- cystoscopy

- The cystoscope is held by working piece and the sheathed scope is lubricated, using Optilube active sterile lubricating jelly with local anaesthetic and introduced into the urethra under vision.
- The cystoscopy is performed.
- If biopsy is required, the biopsy forceps should be removed out of its sterile pack, avoiding de-sterilisation. Once biopsy is obtained, specimen pot is to be labelled

and sent with a histopathology form to the laboratory. The biopsy forceps should be cleaned, packed in its cover and sent to be decontaminated and sterilised.

- If diathermy of the biopsy site is required, the irrigation fluid should be changed to glycine and the bladder emptied and refilled. The diathermy probe should be removed out of its sterile pack, avoiding de-sterilisation. The diathermy probe is then passed through the operating channel of the flexible cystoscope sheath and the other end connected to the diathermy machine. The diathermy machine should be switched on and the power setting adjusted. The foot pedal should be provided to the doctor performing the cystoscopy.
- At the end of the procedure, the cystoscope is removed and replaced it in the holder. The irrigation fluid and the light source should be turned off.
- The procedure including the local anaesthetic agent and batch number should be documented in the patient notes, preferably using the Bulkamid proforma. Appendix 1
- The patient will be counselled regarding after care, and follow up, which should be organised accordingly.

5.5 Removing the Flexi- scope sheath

- After hand washing and drying and gloves, the scope cover should be removed and the cystoscope carefully withdrawn from the sheath. This part of the procedure is helped by grasping the optical lens and keeping the scope straight. Excessive force should not be used to withdraw the scope, as this may result in damage. The sheath is then disposed of.
- The cystoscope should be checked. It should be dry and contamination free. If the sheath is thought to have has been compromised during the procedure, then the list must be abandoned. Contaminated scope must be cleaned with Tristel trio system wipes.

5.6 Cleaning of the Flexi-cystoscope

- Send to SSD for cleaning.

5.7 Using the rigid cystoscope and Bulkamid scope

- The sterilisation date on the pack should be checked and recorded, before opening it.
- The sterilisation pack should be opened, taking care not to desterilise it or desterilise the instruments and equipment in use and on the trolley.
- The cystoscope should be connected to the camera head of the stacking system. The light source and irrigation should be connected and tested. White balance should be ensured.

- Cystoscopy should be carried out in a sterile technique, and using Instillagel, for lubrication and pain relief.
- If biopsy is to be obtained, the rigid cystoscope biopsy forceps should be used. The specimen should be removed from the jaws of the biopsy forceps and placed in the specimen pot. The pot should be labelled and sent with a completed histopathology form to the laboratory.

If diathermy is required, then the diathermy probe should be removed from its sterilisation pack, taking care not to desterilise it or the instruments and equipment in use or on the trolley. The diathermy probe is then passed through the operative channel of the rigid operative cystoscope. The diathermy probe is then connected to the diathermy machine; the diathermy machine is switched on and its power setting adjusted. The diathermy foot pedal is them provided to the doctor performing the cystoscopy.

- After completion of the procedure, the cystoscope, biopsy forceps and diathermy probe should be cleaned and put in their packs separately, to be sent for decontamination and sterilisation.

5.8 Botox bladder wall injection

- Botox bladder wall injection is carried out for detrusor overactivity that does not respond to conservative measures, including fluid advice, bladder training (drill) and at least 2 medications. Appendix 3
- Injections can be carried out through the operative channel of the operative rigid cystoscope. The injection needle will be different; hence it is important to check with the doctor who is covering the clinic and doing the injection.
- The current recommended dose for Botox is 100 units for idiopathic detrusor overactivity. Patients with neurogenic detrusor overactivity have a higher dose. (200 units)
- The Botox should have been prescribed on EPMA in advance and obtained from Pharmacy prior to patient arrival to the Outpatient Cystoscopy Clinic. The dose and expiry date should be checked.
- Botox must be kept in a fridge until the patient appointment.
- The injections should have been discussed at the Urogynaecology Multi-Disciplinary Team Meeting (MDM) and patients should have been counselled and signed the consent already. Patients will be seen at the start of the clinic visit to confirm the need for the injection as well as the patient consent to it.
- The following will be required and should be prepared.
  - 10 ml sodium chloride 0.9% for injection will be required to dilute the Botox.
  - 5 ml sodium chloride 0.9% for injection to flush the needle administering the Botox
  - 10 ml syringe luer lock will be required for diluting and injecting the Botox.
  - 1 ml syringe containing sodium chloride 0.9% for injecting to flush the injection needle, injecting the final 1 ml of the Botox.

  - A blunt red needle will be required for aspirating the sodium chloride from ampule, injecting the sodium chloride into the Botox bottle then aspirating the diluted Botox into the 10 ml syringe.
  - A sterile cleansing wipe.
  - Cooks Williams needle (090001) or Coloplast needle for rigid NBI035.
  - Coloplast needle for flexible NBI070.

- The red needle and the 10 ml syringe should be opened and connected. The 10 ml of saline should be aspirated into the 10 ml syringe, without desterilising the red needle or the syringe. The top of Botox bottle should be exposed and cleansed with sterile cleansing wipe. The 10 ml of sodium chloride 0.9% should then be injected into the Botox bottle, without shaking the bottle (roll and invert gently). A reconstructed Botox should be clear and transparent.
- The 1 ml syringe should be opened and connected to the sterile needle. A 1 ml of sodium chloride 0.9% should be aspirated, to be ready to flush the Botox injection needle, injecting the final ml of Botox.
- The 10 ml syringe containing the reconstructed Botox should be connected to the injection needle, which should be primed before handing it for introduction through the operating channel.
- Botox vial should be disposed of safely. In case of spillage, deactivate Botox with dilute hypochlorite solution 0.5%
- In case of Botox contact with the eye, rinse thoroughly with water.

5.9 Injection of urethral bulking agent

- Patients with stress incontinence of urine may have urethral bulking agents. The plan should have been discussed at the Urogynaecology Multi-Disciplinary Team Meeting (MDM) and patients should have been counselled and signed the consent already. Patients will be seen at the start of the clinic visit to confirm the need for the injection as well as reconfirm consent.
- The urethral bulking agent in use is Bulkamid. The injection is carried out using a special cystoscope provided by the manufacturer. This is a rigid cystoscope that is cleaned and sterilised after each use. One should have been prepared and ready for patients having Bulkamid urethral bulking agent injection.
- Bulkamid comes in special boxes with an injection set, 2 injection needles and 2 Bulkamid syringes. A syringe box and a needle is opened first. If a second syringe is required, then it is opened. Spare (unused) syringes or needles should be kept for future use.
- The injection set is opened alongside the rigid cystoscope, taking care not to desterilise either the set or the cystoscope, or the tray prepared. Using sterile gloves, the syringe to be used should be connected to the injection needle and primed.
- The doctor performing the injection will assemble the cystoscope and injection set. A 1 litre bag of sterile sodium chloride 0.9% should be connected to a sterile

giving set, which will be connected to the cystoscope injection set. The injection set also contains a drainage tube to empty the bladder. The light source and camera head should be connected as well.

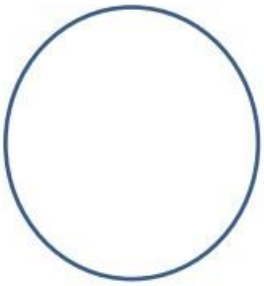
- At the end of the injection, the giving set should be closed and detached from the injection set, the camera head removed from the cystoscope eye piece and cystoscope should be removed from the injection set. The injection set should be discarded as clinical waste. The injection needle should be discarded in the sharps bin. The cystoscope should be cleaned and packed for decontamination and sterilisation.

5.10 Care following outpatient cystoscopy

- Patients should be allowed to dress after the cystoscopy. They should be offered to rest, have a drink and eat biscuits as they wish.
- Patients having Botox bladder wall injection or urethral bulking agent injection should wait till they pass urine and have a bladder scan to ensure that they are passing urine without any problem. Patients passing over 250 ml with <150ml post-void bladder volume on ultrasound scan will be allowed to go home. If retaining urine, then may need to be catheterised and follow TWOC protocol.
- Patients should be informed that their urine might be blood stained initially. They should be reminded that they need to drink more fluids than they normally do, to flush their bladder. If the bleeding does not stop after few days or if they develop painful and/or frequent micturition or fever or feel unwell they should contact their doctor or ring the ward to ensure that they have not developed an infection.

Appendix 1: Bulkamid proforma

Outpatient Bulkamid Proforma

Please complete or affix patient label **Hospital No:**..... **Surname**..... **Forenames**..... **Date of Birth**..... **Age**..... **Address**..... ..... **Postcode**.....	NHS University Hospitals Sussex NHS Foundation Trust
Draw the cushions injected into the circle below, as if it were urethral lumen. 	**Additional Comments:** **UPT: POS/NEG Batch No**..... **Urine dipstick**.....
Number of injection sites: ..... **Percentage Coaptation :** .....% **EBL :** ..... **Consultant name / Signature :**	**First Void :**.....ml **PVR :** .....ml **TWOC Successful Yes No** **Discharge advice**.....

Appendix 2: OP cystoscopy leaflet (IUGA)

Available at: Cystoscopy - Your Pelvic Floor

Appendix 3: Botox Information from IUGA

Botulinum Toxin A (BOTA) for Overactive Bladder and Neurogenic Detrusor Overactivity - Your Pelvic Floor

SOP Governance

Owner	B. Middleton
Author/further information	V. Wong, Consultant Urogynaecologist S. Siddiqui, Consultant Urogynaecologist
Guideline version	v1.0
Related policies	None
Related protocols/procedures	**SRH&WH:** None **PRH&RSCH:** None **UHSx:** None
Standards	NICE NG123 Urinary incontinence & pelvic organ prolapse in women (2019)
Superseded documents	**SRH&WH:** None **PRH&RSCH:** None
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JOGG	Date approved	01/10/25
Women & Children's Clinical Effectiveness Meeting	Date approved	16/10/2025
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Consultation		
ASG	Date approved	03/09/25
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Clinical Document Approval Group	Date approved	29/10/2025

SOP Version Control

Version	Date	Author	Comment
1.0	May 2025	V. Wong, Consultant Urogynaecologist S. Siddiqui, Consultant Urogynaecologist	New Trust wide guidance.