Pain Management During In-Office Gynecologic Procedures

Gail Zeisler

College of Nursing, East Carolina University

Doctor of Nursing Practice

Executive Summary

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Main Points

- Decisions regarding pain management for in-office gynecologic procedures are left to each individual clinic
- EMLA cream is an acceptable option
- 75% of providers who participated in the project agreed that the EMLA cream was available when needed, caused minimal inconvenience to use, and provided satisfaction as a healthcare provider.
- Patient experience scores varied
- Project met the Quadruple Aim in improvement of patient experience, improvement in population, cost effectiveness, and provider satisfaction

Introduction

Women are in a vulnerable position during a gynecologic examination. The environment, the patient's history with previous examinations and procedures, or previous sexual experiences can influence how the patient manages each appointment and examination (ACOG, 2025). While a list of options for pain management during these procedures is available, there are no specific guidelines on which intervention to use, and it is difficult to select one intervention to suit all patients. In a gynecologic oncology clinic in eastern North Carolina, there are no interventions for pain management during specific procedures, including endometrial biopsies, vaginal biopsies, cervical biopsies, and IUD placements. The purpose of this project was to determine whether EMLA cream could be used effectively and efficiently in this clinic for pain management during these specific procedures (ACOG, 2025). The results of the project will be discussed with the clinic's providers for potential permanent use of EMLA cream. It is hoped that once a protocol can be implemented in this clinic, it may be disseminated to other clinics within the healthcare system.

Methodology

The project involved four providers, three medical doctors and one nurse practitioner, as well as 26 patients aged 33 to 87 completing 30 procedures. Six cycles of the PDSA framework were completed over the course of twelve weeks. Once a patient was determined to be appropriate to participate in the project, she consented to the procedure and was asked if she would like to be part of the project. EMLA cream was applied to the area of biopsy or where pain from instrumentation would be anticipated. EMLA cream was allowed to be in place for seven minutes before the procedure was started (Bayer et al., 2025). Each participating patient was asked to complete a questionnaire to determine their pain level prior to the start of the procedure, immediately after the procedure, and at ten minutes after the procedure. They were asked to rate their pain on a 0-10 scale. Each patient was also asked whether they had ever had this procedure completed in the past; if so, they were asked to describe their previous experience compared to that of the day. They were also given the opportunity to provide additional comments regarding the experience. The providers were asked to complete surveys regarding their thoughts on the project and their experiences at the six-week point and again at the end of the project, at the twelve-week point.

Results

Regarding the providers' surveys, 100% of the providers believed that the EMLA cream was available when needed but did note that it was not being stored in the most convenient location. The same 75% of the providers felt that there was minimal interference with the clinic flow when using the EMLA cream for procedures. The same 75% of the providers felt satisfied that they were providing the best care for their patients when using the EMLA during those procedures, and they would like to continue using the EMLA cream after the conclusion of the project. The one provider who did not wish to continue using EMLA cream stated that he would be more inclined to do so if patient benefit was proven. Patient results were varied. On a pain scale of 0-10, 23 out of the 26 patients noted a pain score

of 0-2 prior to the procedure. The assessment immediately after the procedure found 80% of the patients with a score in the 0-2 range and 15% in the 3-6 range. The final timed assessment at ten minutes post-procedure found 88.5% in the range of 2-3 and 11.5% in the range of 7-10. Six of the 26 patients had undergone the same procedure in the past. Compared with previous experiences, three felt the discomfort was less, one found it to be similar, and two felt that there was more discomfort.

Strengths and Limitations

Strengths of the project included the engagement of the entire clinic from providers to nurses to nursing assistants. The small number of providers participating ensured minimal procedural variation, allowing EMLA cream to affect perceived pain. EMLA cream was used in a one-gram dose (the entire package), eliminating the chance of different dosages and effects. Limitations of the project include the time-frame restriction of twelve weeks. This time limited the number of patient participants and possibly the providers' opinions.

Implications and Conclusions

One practical implication from this project is that an intervention can be implemented in the clinic for pain management during these specific procedures and possibly others. If it is determined that EMLA cream is not the optimal intervention, a different option can be used. Theoretical implications include a trusting relationship between the provider and the patient, based on the patient believing that their provider is making every effort to provide the best possible care. This trusting relationship can allow the patient to be more willing to continue her care and endure additional procedures if necessary. Should continued care result in the identification of a disease condition, it will hopefully have been diagnosed early and lead to better prognosis and optimal outcomes. In conclusion, pain management is necessary for the procedures and possibly others. EMLA cream is a possible option for this clinic; however, it may not be the only option. Recommendations for future discussion include reviewing

patient outcome data, provider feedback, clinic workflow, and the feasibility of adopting EMLA cream as part of a standardized pain-management protocol.

References

ACOG American College of Obstetricians and Gynecologists. (2025). Pain management for in-office uterine and cervical procedures. *Committee on Clinical Consensus – Gynecology.* https://www.acog.org/clinical-guidance/clinical-consensus/articles/2025/05/pain-management-for-in-office-uterine-and-cervical-procedures

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