

HYSTEROSCOPY FOR SEVERE ASHERMAN SYNDROME

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INTRODUCTION

In 1948 Joseph G. Asherman described the syndrome of amenorrhea secondary to cervical stenosis and intrauterine adhesions⁽¹⁾. It may result in menstrual abnormalities, infertility, recurrent pregnancy loss, premature labor, and placenta previa or accreta. Hysteroscopy is the best method to diagnose and treat Asherman syndrome⁽²⁾. There are few reports in the literature which evaluate the efficacy of hysteroscopic treatment of severe Asherman syndrome. The objective of this study is to provide the menstrual and fertility outcome after hysteroscopic treatment of severe Asherman syndrome.

From January 1997 through January 2007, all hysteroscopic procedures' operative notes at King Abdulaziz University Hospital, Jeddah, Saudi Arabia were reviewed. The records of women with hysteroscopically diagnosed severe Asherman syndrome; stage IV (according to the European Society of Hysteroscopy) ⁽³⁾ with complete obliteration or "agglutinated" uterine cavity with

occlusion of both ostial areas were retrieved. Seven women met these criteria, and were selected and reviewed. They presented with secondary amenorrhea and infertility. Their mean age was 30.2 years, and mean parity was 4. Six women had at least one cesarean section and four women had also at least one dilatation and curettage. One woman had five previous dilatation and curettage. Investigations showed normal semen analysis and normal hormonal profile. All had hysterosalpingography and were found to have a completely obliterated uterine cavity. Hysteroscopy was performed under laparoscopic guidance by a single surgeon (A. A. Rouzi). Uterine adhesions were divided using monopolar energy resectoscope. All women received single dose of intravenous prophylactic antibiotic. Intrauterine contraceptive device was inserted in two women. Post-operative hormonal therapy was given to all women.

The procedure was done with no complication in all women, except one uterine perforation during cervical dilatation. All women resumed their menstruation after the first procedure. However, three

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women had to repeat the procedure to maintain their menses. The uterine cavity was restored in all women (after one hysteroscopic procedure in five women, after two hysteroscopic procedures in one woman, and after three hysteroscopic procedures in one woman). The mean follow up was 4 years. Only one woman got a spontaneous pregnancy but aborted at 20 weeks and had retained placenta which was removed surgically.

Hysteroscopic surgery is currently the optimal approach which has dramatically allowed the rapid improvement of diagnosis and treatment of intrauterine adhesions. The true incidence of this condition is difficult to determine ranging from 1.5% of patients referred for fertility testing and up to 40% of women following secondary removal of placental tissue or repeat curettage after a missed abortion⁽⁴⁾.

Many methods were described in the literature for treatment of Asherman syndrome. These include blunt dissection with forceps, sharp dissection with hysteroscopic scissor, resectoscope, knife electrode, curettage, or combinations. The principal risk of the procedure is the ease of uterine perforation during instrumentation. Hysteroscopy under laparoscopic guidance readily diagnose but not guard against uterine perforation. The possible use of ultrasound guidance for this matter was recently described. In addition, fluoroscopically guided synechiolysis under image intensifier control appears to be an effective treatment with the possibility of early detection of

false passage⁽²⁾. Severe Asherman syndrome is a special situation⁽⁵⁾. It is a difficult condition to treat and restoration of normal uterine cavity by hysteroscopy is not always possible. Furthermore, after surgery, normal endometrial function is not guaranteed. Our case series shows that hysteroscopic treatment is effective in resumption of menses but not pregnancy.

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