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Case Report

Alleviating ashermans: a success story

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ABSTRACT

Asherman syndrome (AS) is characterised by formation of intrauterine synechia due to the destruction of basal layer of endometrium. It presents as oligomenorrhea, amenorrhoea and infertility. Treating Ashermans is a challenge. Patient XYZ, 28 years, presented with complaints of amenorrhea for 11/2 years. She was diagnosed with Ashermans Syndrome outside but the treatment did not work. We first gave cyclical hormones followed by hysteroscopic adhesiolysis. She conceived immediately after return of menses and delivered a term baby. Currently she has regular menstruation. Conclusion: Building up the endometrium on hormonal support pre- and post-surgery and instant conception on return of menstruation was the factor leading to successful management.

Keywords: Asherman, Hysteroscopy, Tuberculosis, Infertility

INTRODUCTION

Asherman syndrome (AS) is characterised by formation of intrauterine synechia due to the destruction of basal layer of endometrium. Prevalence of AS is 1.5%. Most common causes are dilatation and curettage, hysterotomy, hysteroscopic polypectomy or myomectomy, caesarean section and open myomectomy.[1]

In developing nations, infectious causes like tuberculosis, is a major causative factor.[2] It presents as oligomenorrhea, amenorrhoea and infertility due to intrauterine adhesions which may lead to complete obliteration of endometrial cavity.[1]

Hysteroscopy is the gold standard for diagnosis and management. However, there have been concerns of failure of treatment, recurrence of adhesions and formation of new adhesions.[1] A single centre study reported the live birth rate in mild cases is as low as 43.4%. Pregnancy rates in severe cases are 9-10%.[3]

Objective

To alleviate the challenge of managing Ashermans.

CASE REPORT

Patient XYZ, 28 years, Indian, presented with complaints of amenorrhea for 11/2 years. She had one previous live birth by caesarean section, 6 years ago and history of two spontaneous abortions, four and two years ago, both followed by dilatation and curettage. She complained of oligomenorrhea for 5 months following amenorrhea for 1.5 years. She had presented to some hospital outside where she was diagnosed with AS.

Hysteroscopic adhesiolysis was done and she was prescribed Antitubercular Drugs on suspicion of tuberculosis. However, there was no improvement. Hence, she presented to AIIMS, Raipur.

On examination, there was no gross abnormality. Ultrasound (Figure 1 A) showed dense adhesions obliterating the uterine cavity and Saline Infusion Sonography (SIS) (Figure 1 B) showed no fluid in cavity. Both were suggestive of AS. Hysteroscopy was advised but patient was unwilling, thus, she was given tablet Conjugated Equine Estrogen (Premarin®) for 1st 25 days and Medroxyprogesterone acetate from 15th to 26th day for 3 cycles and she had spotting. Then hysteroscopy was

done and dense adhesions were seen. Adhesiolysis was done with scissors. Right ostium was visible and the left ostium had an overlying fibrous band (Figure 2) which was resected with scissors. Premarin® with Medroxyprogesterone acetate therapy was advised for 3 cycles. The polymerase chain reaction for tuberculosis (TB-PCR) of the sample sent was reported negative.

There was return of her menstruation within a month but she missed her period the following month. Urine pregnancy test (UPT) was positive. Dating scan, Early anomaly scan, Dual markers, Anomaly scan were all normal. She was on progesterone support throughout the pregnancy. She delivered a term, alive, boy baby of weight 2.94 kg by caesarean section. Both mother and baby are healthy. She has regular menstruation and has not required any further medication.

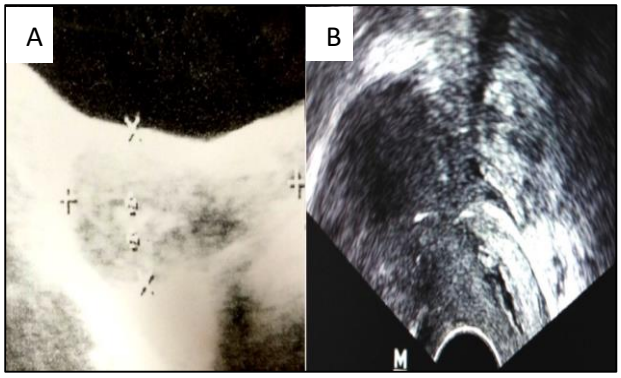

Figure 1: (A) Transvaginal ultrasound pelvis showed dense adhesions obliterating the uterine cavity. (B) Saline infusion sonography (SIS) showed no fluid in cavity.

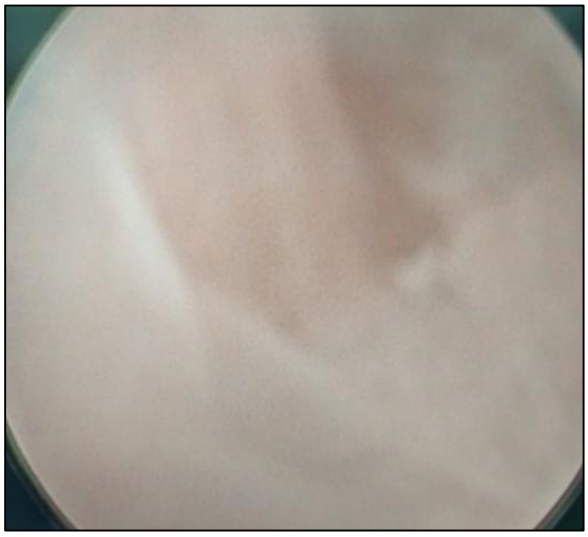

Figure 2: Hysteroscopy image showing fibrous band covering left ostium.

DISCUSSION

AS accounts for 4.6% of cases of infertility.[3] Thus, it is a rare disease; however, it is very difficult to manage and requires skill and perseverance.

Dilatation and curettage accounts for 90% cases of AS.[1] Our patient had undergone dilatation and curettage twice, thus being predisposed to the disease. In a developing nation like India, tuberculosis has a major role in causation of both infertility and AS. The treatment is a challenge as there is chance of failure, recurrence and pregnancy related complications like abortion, stillbirth, placenta accreta. In severe cases of AS, the pregnancy rates were almost as low as 9%.[2] History of antitubercular treatment in the past aided our current intervention and prevented relapse.

Hysteroscopic surgery revolutionised treatment of AS. Even though electrosurgical instruments were efficient in adhesiolysis, they also caused thermal damage to the remaining endometrium.[4] Cold knife adhesiolysis prevented this very phenomenon. In our patient, scissors were used to dissect the adhesions without any use of the electrosurgical unit.

CONCLUSION

In our patient, tuberculosis (if any) was already treated outside. This time only the adhesiolysis and hormone treatment worked for her. Also, building up the endometrium on hormonal support post-surgery and instant conception on return of menstruation was the factor leading to successful management.

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