International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Goel S et al. Int J Reprod Contracept Obstet Gynecol. 2025 Aug;14(8):2792-2794
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20252364

Case Report

Uterine calcifications identified and removed via hysteroscopy in two patients with prior dilatation and curettage

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Received: 11 June 2025
Revised: 10 July 2025
Accepted: 12 July 2025

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ABSTRACT

Uterine calcification is a rare finding that may result from prior uterine trauma such as dilatation and curettage (D and C). We report two cases of women with prior D and C presenting with menstrual disturbances-one with amenorrhoea and another with menorrhagia. Imaging revealed intrauterine calcifications, which were removed via hysteroscopy using a nephroscope and forceps. Postoperative follow-up indicated significant symptomatic improvement and restoration of menstrual regularity. Hysteroscopic removal of uterine calcifications offers an effective and minimally invasive treatment option, particularly in post-D and C patients.

Keywords: Uterine calcification, Hysteroscopy, Dilatation and curettage, Amenorrhoea, Menorrhagia

INTRODUCTION

Uterine calcifications are an unusual but well-documented consequence of uterine trauma, including previous surgical procedures like D and C.[1]

Such calcifications may occur as a result of retained products of conception, infection, or trauma to the uterine wall.[2] They can cause a variety of menstrual disturbances, such as amenorrhoea, menorrhagia, or irregular cycles and infertility.[3] Hysteroscopy allows for direct visualization of the uterine cavity and is the gold standard for diagnosis and management of intrauterine pathology.[4] In this report, we present two cases of uterine calcifications removed via hysteroscopy in patients with a history of D and C, highlighting the efficacy of the nephroscope and forceps approach.[5,6]

CASE REPORT

A 34-year-old female and a 29-year-old female both present with menstrual irregularities following D and C procedures after spontaneous miscarriages. The 34-year-old patient underwent a D and C 18 months ago and initially had normal menstruation but later developed amenorrhoea for six consecutive months, without pelvic pain, abnormal vaginal discharge, or infertility issues. The 29-year-old patient, who had a D and C 24 months ago due to retained tissue, now reports menorrhagia and frequent menstrual cycles every 21 days, along with intermittent spotting between cycles.[3]

Her symptoms have worsened over the past six months, though she denies significant pelvic pain or other concerning symptoms. In both cases, most frequent diagnostic method pelvic ultrasound revealed an irregular, thin endometrial lining with evidence of scarring within the uterine cavity.[4]

Hysteroscopy confirmed the presence of multiple small calcified deposits within the endometrial cavity, likely remnants from the prior D and C procedure (Figure 1). These calcifications appeared well-organized and were not associated with active inflammation. CT scan confirmed the presence of multiple small calcifications, consistent with post-procedural scarring and retained products of conception.

Outcome

Following hysteroscopy removal of coral calcified deposits, both patients experienced improvements in their menstrual cycles. The 34-year-old patient's cycles resumed after two months, returning to a regular pattern, and by the 6-week follow-up, she reported no further issues with amenorrhoea. Similarly, the 29-year-old patient experienced a significant reduction in the frequency and intensity of her menstrual bleeding, with her cycles becoming more regular (28 days) and the flow reduced. At the 6-week follow-up, both patients reported significant symptom improvement (Figure 3). Histopathological examination of the removed material from both procedures confirmed the presence of osseous metaplasia and no malignancy or infection was detected.[5]

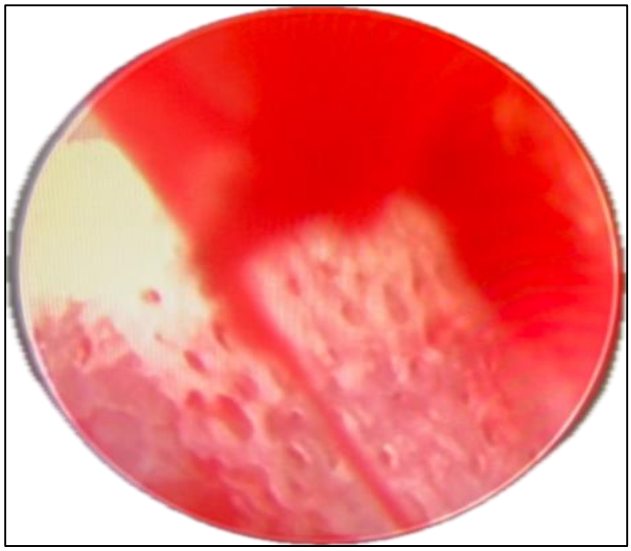

Figure 1: Hysteroscopic calcified deposits within the endometrial cavity.

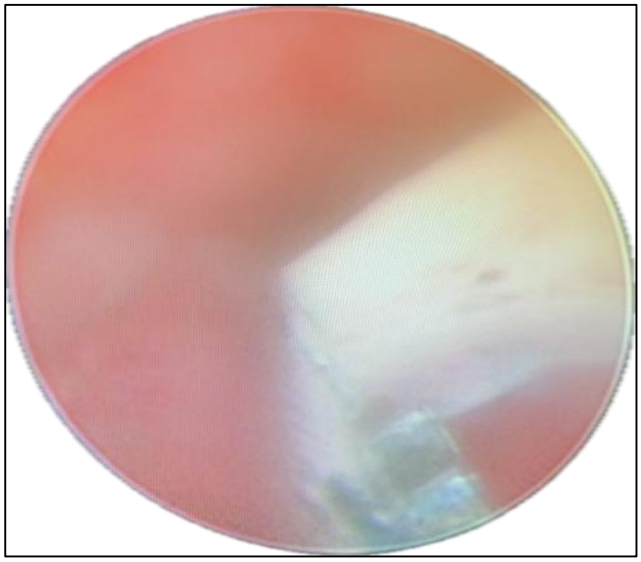

Figure 2: Nephroscope and forceps technique for removal of these calcifications.

Figure 3: Removed calcified material sent histopathological examination.

DISCUSSION

The development of calcifications in the uterine cavity is a rare but recognized complication following D and C, particularly when associated with retained products of conception.[6] The process typically involves the deposition of calcium salts in response to necrosis or fibrotic changes in the endometrial tissue. These calcifications can be found within the uterine cavity or in the endometrial lining itself, often causing disruption of normal menstrual function.

In both cases presented here, the calcifications likely arose due to incomplete expulsion of tissue during the initial miscarriage and D and C. The calcifications act as a form of endometrial scar tissue that can cause menstrual abnormalities, including amenorrhoea in one and heavy or frequent periods and infertility.[6] The nephroscope and forceps technique for removal of these calcifications (Figure 2) like bony fragments has been shown to be safe and effective in restoring normal uterine function, with both patients reporting significant improvements in menstrual symptoms following the procedure.[7]

CONCLUSION

Uterine calcifications can complicate the post-D and C recovery process and lead to menstrual irregularities such as amenorrhoea or menorrhagia. Hysteroscopic evaluation with nephroscope-assisted removal of calcifications is an effective and minimally invasive approach for managing these complications. In this case report, two patients with a history of D and C procedures underwent successful hysteroscopic removal of calcifications, resulting in

significant improvements in their menstrual cycles. Further research is needed to optimize the management of uterine calcifications.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Tulandi T, Al-Sunaidi M, Arseneau J. Calcified tissue of origin in utero. Fertil Steril. 2008;89(1):217-8.
2. Moon HS, Park YH, Kwon HY. Iatrogenic secondary infertility caused by residual intrauterine fetal bone after midtrimester abortion. Am J Obstet Gynecol. 1997;176(2):369-70.
3. Mohan H, Nada R, Mohan P. Endometrial ossification in infertile patients-report of three cases. Aust N Z J Obstet Gynaecol. 1999;39(4):513-5.
4. Feyles V, Moyana TN, Pierson RA. Recurrent pregnancy loss associated with endometrial hyperechoic areas (endometrial calcifications): a case report and review of the literature. Clin Exp Obstet Gynecol. 2000;27(1):5-8.
5. Chervenak FA, Amin HK, Neuwirth RS. Symptomatic intrauterine retention of fetal bones. Obstet Gynecol. 1982;59(6):58-61.
6. Bahçeci M, Demirel LC. Osseous metaplasia of the endometrium: a rare cause of infertility and its hysteroscopic management. Hum Reprod. 1996;11(11):2537-9.
7. Basu M, Mammen C, Owen E. Bony fragments in the uterus: an association with secondary subfertility. Ultrasound Obstet Gynecol. 2003;22(4):402-6.

Cite this article as: Goel S, Goel B, Modh M. Uterine calcifications identified and removed via hysteroscopy in two patients with prior dilatation and curettage. Int J Reprod Contracept Obstet Gynecol 2025;14:2792-4.