Successful Live Birth Following Hysteroscopic Adhesiolysis with MyoSure for Asherman Syndrome

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Introduction

Asherman syndrome is an acquired condition characterised by intrauterine adhesions which obliterate the endometrial cavity and cause menstrual or reproductive dysfunction[1]. Majority of cases occur following pregnancy-related dilation and curettage[2]. Hysteroscopy is currently the gold standard for diagnosis and concurrent treatment[1].

We present a case of a 28-year-old woman who successfully gave birth following hysteroscopic adhesiolysis with MyoSure for Asherman syndrome.

Case Report

A 28-year-old woman, G3P1, was seen for dysmenorrhoea one year following a vaginal birth with manual removal of placenta and return to theatre for dilation and curettage for retained products of conception. She was diagnosed with Asherman syndrome and underwent hysteroscopic adhesiolysis with MyoSure and adjuvant estrogen therapy months later hoping to conceive.

References:
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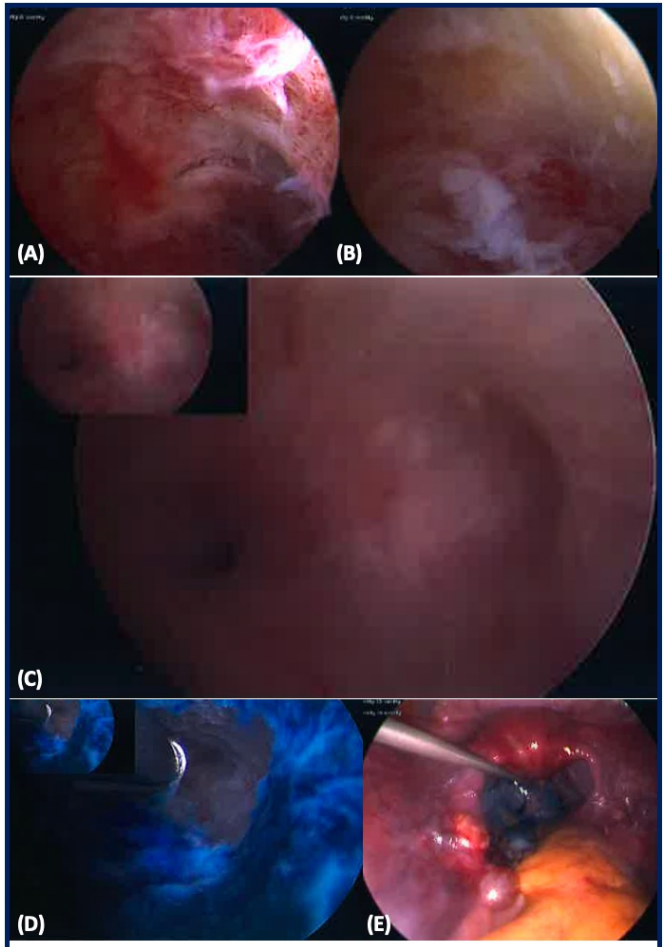

Figure 1 – Hysteroscopic view of: (A & B) intrauterine adhesions or Asherman syndrome; (C) obliterated left ostium and patent right ostium; and (D) dye test following adhesiolysis with Myosure at left ostium. (E) Laparoscopic view of dye spillage confirming bilateral patent tubal patency.

Results

Initial hysteroscopy revealed an obliterated endometrial cavity with both ostia not visible, confirming Asherman syndrome (Figure 1A & 1B). Adhesiolysis was done via hydrodilation at the time. A second-look hysteroscopy months later showed intrauterine adhesions obliterating the left ostium (Figure 1C). The right ostium was unaffected. Adhesiolysis with MyoSure was performed. A dye test and check hysteroscopy revealed bilateral tubal patency and confirmed restoration of the endometrial cavity post MyoSure adhesiolysis (Figure 1D & 1E). Estrogen therapy was prescribed post-op for a period of four weeks. Four months later, she conceived and eventually gave birth to a live neonate at term.

Discussion & Conclusion

Hysteroscopic adhesiolysis is used for diagnosing and treating Asherman syndrome in symptomatic women. Still, recurrence post-surgery is high[3]. Novel modalities are being explored with aim of restoring anatomy and function and improving fertility outcomes. These include using mechanical energy systems with limited cutting depth, such as MyoSure, to avoid endometrial injury and second-look hysteroscopy with complementary therapies to prevent recurrence[3,4]. Thus far, there have been favourable outcomes, as with our case, but ongoing research to determine their efficacy is required.