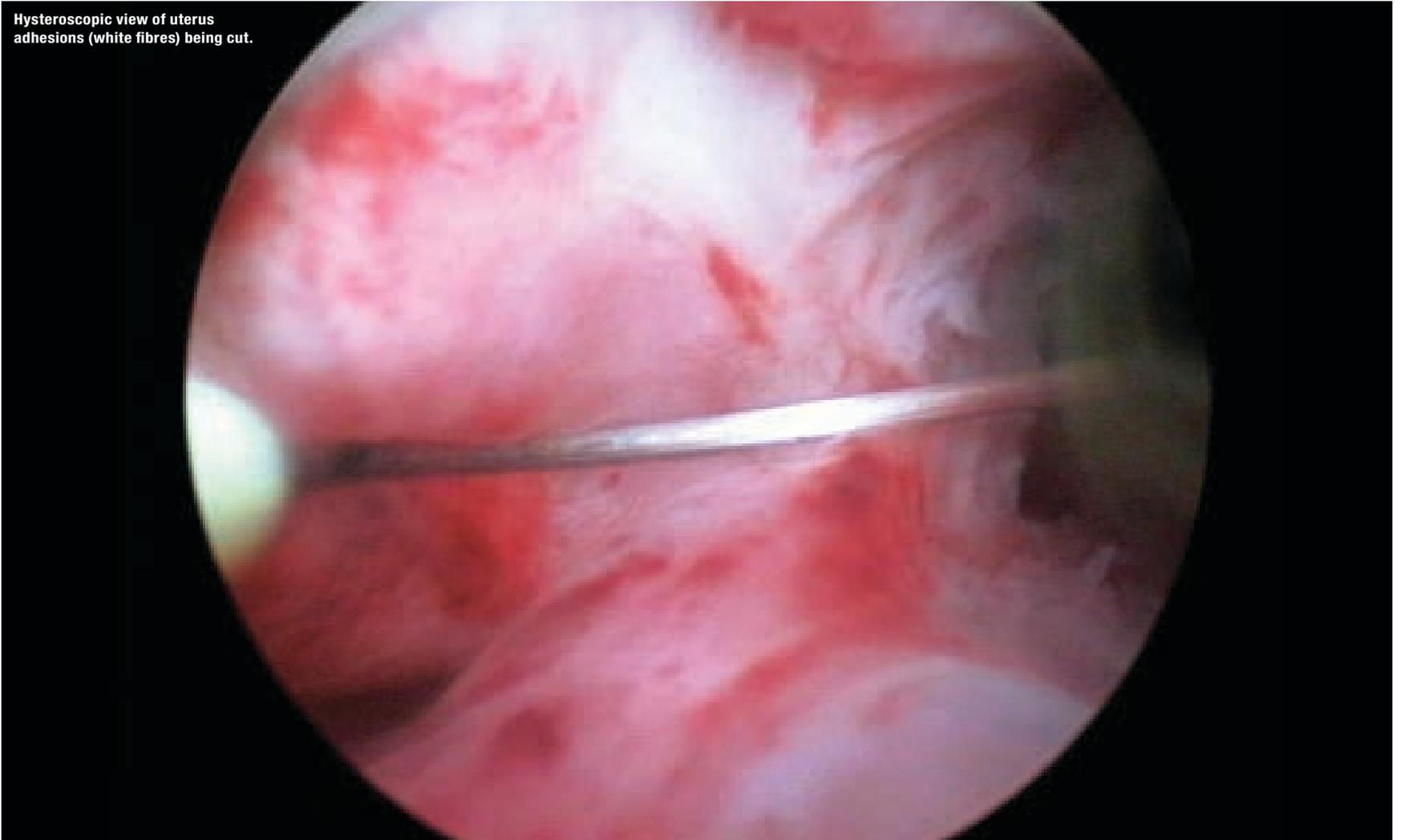


Hysteroscopic view of uterus
adhesions (white fibres) being cut.



A rare infertility disorder



PROFESSOR THIERRY G. VANCAILLIE MD (BELGIUM)

Gynaecologist and pain medicine specialist, Women's Health and Research Institute of Australia

Asherman's syndrome: an acquired disorder with consequences for fertility.

ASHERMAN'S syndrome (AS) is an acquired uterine disorder, characterised by the formation of adhesions within the uterine cavity and/or cervical canal.

The true prevalence of AS is unclear due to under-diagnosis. It is estimated to affect 1.5% of women undergoing a hysterosalpingogram, between 5% and 39% of women with recurrent miscarriage and up to 40% of women who have undergone repeat dilation and curettage (D&C) for retained products of conception following pregnancy.

SYMPTOMS

The majority of AS patients have no symptoms at all. A decrease in menstrual flow may occur, however this is difficult to measure.

Patients present for treatment if they fail to become pregnant or if they have significant increase in dysmenorrhoea or complete absence of menses.

Most symptoms occur within close proximity to a pregnancy, usually within four months and usually while the woman is in a hypo-oestrogenised state, as after miscarriage or childbirth.

REPRODUCTIVE IMPACT

The reproductive consequences of AS include infertility, recurrent miscarriage, intrauterine growth restriction and placenta accreta.

CAUSES

There is a pervasive belief AS develops as the result of aggressive curettage however, this is not the case, at least not as a single cause.

AS is most likely the result of a set of circumstances including recent pregnancy, instrumentation and inflammation (possibly due to sub-clinical infection) plus genetic predisposition.

Most commonly intrauterine adhesions occur after a D&C performed because of a missed or incomplete miscarriage, retained placenta, post-partum haemorrhage or abortion.

Pregnancy-related D&Cs have been shown to account for 90% of AS cases. Sometimes adhesions also occur following other pelvic surgery such as caesarean section, hysteroscopic resection of submucosal fibroids or polyps, or in the developing world, as a result of infections such as genital tuberculosis and schistosomiasis.

DIAGNOSIS

The diagnosis of AS is primarily by history and a high index of suspicion. Hysteroscopy is the gold standard.

The stage of disease is determined by the extent of adhesions and endometrial cavity involved, the type of adhesions (filmy or dense) and the menstrual pattern.

The adhesions can be thin or thick, spotty in location or confluent. They are usually not vascular, which is an important attribute in treatment.

There are four stages of disease: Stage I (mild), Stage II (moderate), Stage III (severe) and Stage IV (complete obliteration of the uterine cavity).

TREATMENT

First-line treatment of AS is to remove the scar tissue and promote the growth of the

Practice points

Maintain a high level of suspicion in patients presenting with:

- symptoms within close proximity to a pregnancy
- a decrease in menstrual flow (hard to measure) or complete absence of menses
- increase in dysmenorrhoea
- subfertility.

Refer to a surgeon specialising in this area.

endometrium to reduce the formation of new scar tissue. Hysteroscopic lysis of adhesions is the main method of treatment.

Hormone support therapy is used in almost all cases, except in stage I. Use of a stent to keep the uterine walls separated during the healing phase, is recommended in stages III or IV. Repeat intervention is common in stage III and IV. Increasingly early re-intervention either with standard hysteroscopy, or most recently with flexible hysteroscopy, has been advocated.

TREATMENT OUTCOMES

Pregnancy success following treatment is around 90% for

stage I, 60% for stage II and 30% for stage III with pregnancy after stage IV uncommon.

Risks after treatment of AS include: small for dates, slightly higher incidence of miscarriage and preterm delivery, and 5% risk of major haemorrhagic complication at delivery due to placenta accreta.

PREVENTION

Incidence of intrauterine adhesions might be lower following medical evacuation (e.g. misoprostol) of the uterus, thus avoiding any intrauterine instrumentation.

Also, the use of systematic antibiotics after D&C to avoid sub-clinical infections, likely a cofactor in the genesis of scarring, might be beneficial.

There is no evidence to suggest suction D&C is less likely to result in adhesions than sharp D&C. Cases of AS have been reported even following manual evacuation, and the rate of AS has not dropped since the introduction of suction D&C.

Jean Hailes for Women's Health is a national, not-for-profit organisation focusing on clinical care, innovative research and practical educational opportunities for health professionals and women. www.jeanhailes.org.au