

PREGNANCY AFTER A SHERMAN'S SYNDROM
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Objective

Asherman's syndrome, which is also referred to as intrauterine adhesion or intrauterine synechiae, occurs when scar tissue (adhesions) forms inside the uterus and/or the cervix.

Most patients with Asherman's syndrome present with infertility and menstrual problems. hysteroscopic adhesiolysis remains the gold standard for diagnosing the extent of the disease and allows treatment to occur simultaneously.

Case report

Our patient is 32 years old, Para 2+1, presented with complain of amenorrhea for six months after miscarriage which was treated surgically.

Her surgical history included manual removal of placenta twice after vaginal deliveries and evacuation of retained product of conception post miscarriage.

Her investigations showed negative pregnancy test, normal hormonal profile and the pelvic ultrasound revealed thin endometrium and normal ovaries.

The patient was started on Progesterone tablets for withdrawal bleeding with no effect.

Then she was commenced on Oestrogen and Progesterone followed by hysteroscopic adhesiolysis and continued on hormonal treatment.

One month after the procedure our patient had her period back and her ultrasound was showing endometrial thickness of 9.3 mm.

Our patient got pregnant after two months of the procedure. currently she is thirty-three weeks gestation, was diagnosed with placenta previa and had recurrent antepartum haemorrhage for which she was admitted to the hospital from twenty-seven weeks of gestation.

Discussion

The failure to induce menses despite stimulating the endometrium with an estrogen-progesterone challenge, in a patient with secondary amenorrhea, with normal hypothalamic-pituitary-ovarian functions and hormone levels, points towards the diagnosis of Asherman's syndrome

The lesions range from minor to severe adhesions that affect menstrual function and fertility. The chances of conceiving and delivery after surgery are lower in patients with moderate to severe disease but may improve after surgery if the cavity can be reconstructed and menses recur.

Although two-dimensional sonography may suggest adhesive disease, Asherman syndrome is more often evaluated initially with saline sonography or hysterosalpingography to demonstrate the adhesions. Hysteroscopy remains the gold standard for diagnosing the extent of the disease and treating it at the same time.

Placenta previa and accreta must be considered as a potential complication in pregnancies after hysteroscopic adhesiolysis for Asherman's syndrome.

Conclusion

Hysteroscopic adhesiolysis is a suitable treatment method for Asherman's syndrome. Subfertile patients with Asherman's syndrome undergoing adhesiolysis should be appropriately informed about the risk of associated life-threatening complications such as placenta previa, accreta, antepartum haemorrhage and preterm delivery.

References:

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