

N HYSTEROSCOPY NEWSLETTER

I remember that at the beginning of the 90's, during my residency in Paris, at the Hospital de Clamart, with Professors Frydman and Fernández, I was seduced by this surgical technique: Hysteroscopy, both in office and in the operating room.

I returned to Peru in the year 1995. A time when gynecological laparoscopy was booming in the country, both in the public sector and in private medicine, as it was very well received and accepted. However, the same did not happen with Hysteroscopy. Only few doctors were promoting its development, one of them was Dr. Jaime Seminario. At that time, we performed Office Hysteroscopy with a 4 mm lens, a Histeroflator and without using anesthesia. Despite the courses we organized, we saw that Hysteroscopy did not grow at the same rate as its older sister, Laparoscopy. However, over the last 3 years I have seen greater enthusiasm, interest and motivation from residents, as well as young gynecologists to embrace Hysteroscopy.

In 2019, we held the first Hysteroscopy workshop with the participation of 40 doctors, where 60 Hysteroscopies were performed. These were carried out by the same students under tutoring. 8 highly complex surgeries were also performed, broadcasted from the operating room to the auditorium. We had such a great success, that we had to hold a second workshop the following month given the high demand and interest. This confirmed the current interest for hysteroscopy in Peru, which for us was a source of encouragement to continue working on the development of this surgical technique.

Thanks to the important technological development in hysteroscopic instruments and the continuous training of physicians, Hysteroscopy is conquering its well-deserved place within our specialty. We see the great interest of gynecologists to learn and perform office hysteroscopy with the concept of "see and treat" in a single visit, which will be a major benefit for our patients.

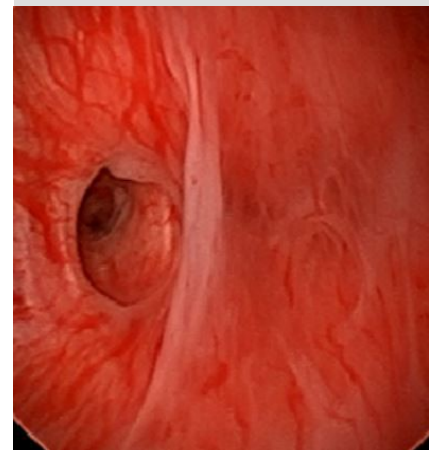
It is important to change the concept that Surgical Hysteroscopy is "a small surgery". It must be considered a true surgical procedure that requires precise knowledge of the technique to obtain all its benefits, because the consequences of a bad surgery can have serious deleterious impact in the reproductive future of the patient.



Our goal is that all gynecologists embrace Hysteroscopy as a diagnostic and treatment tool in their office. Also, that they know which surgeries are better performed under anesthesia, in the operating room, with the appropriate instruments and equipment. In the same way, knowing when to refer the patient to a referral center.

Julio Diaz Pinillos
Peru

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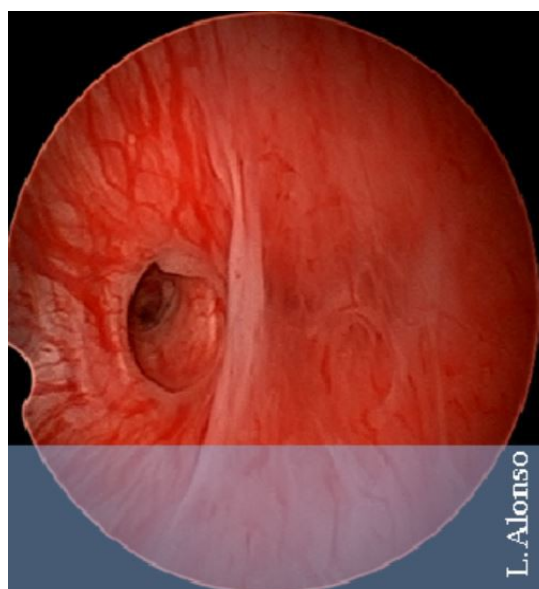
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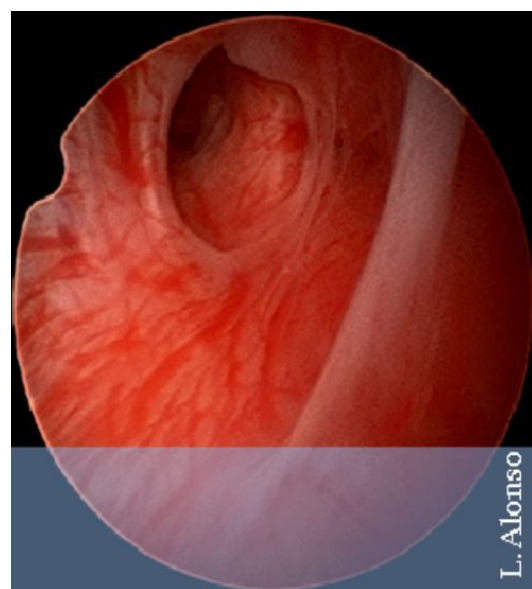
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HYSTEROSCOPY PICTURES



L. Alonso

*Irregular endometrium
with tiny openings*



L. Alonso

*Detailed view of the
defect*

Adenomyosis is defined as the presence of endometrium within the myometrium and it is a gynecological condition commonly encountered in clinical practice. Most of the patients are asymptomatic but others can have menorrhagia (40–50%) or metrorrhagia (10–12%), dysmenorrhea (30%), dyspareunia, infertility and chronic pelvic pain. The use of 3D ultrasound and MRI can help to establish the diagnosis of adenomyosis. Hormonal treatment can relieve symptoms and reduce the progression of the disease, but is limited by the side effects. Hysterectomy and LNG intrauterine system is still the cornerstone of treatment. (<https://doi.org/10.1016/j.gmit.2015.08.003>)

Diagnostic hysteroscopy cannot establish a definitive diagnosis of adenomyosis, considering that its field of vision is restricted to the endometrial surface layer. The following aspects are generally indicative of the pathological condition:

- (i) *Irregular endometrium with tiny openings seen on the endometrial surface*
- (ii) *Pronounced hypervascularization;*
- (iii) *An endometrial “strawberry” pattern*
- (iv) *Fibrous cystic appearance of intrauterine lesions*
- (v) *Haemorrhagic cystic lesions with dark blue or chocolate brown appearance*

<https://doi.org/10.1155/2017/2518396>

If you are interested in sharing your cases or have a hysteroscopy image that you consider unique and want to share, send it to hysteronews@gmail.com

INTERVIEW WITH...

A GREAT and DEEP knowledge of the uterus and its secrets

How important is the role of the hysteroscopy in an IVF unit?

For many years the uterus was a neglected incubator. If patients are referred to an IVF program evaluation of the uterine cavity is an important issue. Ideally this has to be done by a combination of ultrasound and hysteroscopy. Ultrasound is superior in visualization and measuring the uterine borders, important to make the difference in diagnosis of the different congenital uterine anomalies. Hysteroscopy shows us the aspect of the endometrium and allows the detection of endometrial lesions not always seen at ultrasound. Although small polyps are maybe not important for achieving a spontaneous conception, in case of IVF and when performing an embryo transfer, these polyps can be a mechanical obstacle to perform a correct release of the embryo in a virtual cavity.

As more patients are consulting at a later age, more such pathologies can be expected. This is certainly the case for adenomyosis. These adenomyotic defects of the endometrium can easily be visualized at hysteroscopy. The conclusion of the Trophy study stating that there is no place for hysteroscopy in patients referred to an IVF program cannot be concluded from this study as the initial question of this study was if it makes sense to perform a hysteroscopy the *cycle before* an IVF attempt to increase the pregnancy rate. In the consecutive cycle. As vagino-cervico-hysteroscopy is at this stage a minimal invasive procedure, as proven by the Trophy study, and easily performed in an outpatient setting, it can only be a benefit for the patient. Only by performing a systematic examination of the uterine cavity we will be able at least to understand better the role and importance of the uterine aberrations in the process of implantation and pregnancy outcome.

“For many years the uterus was a neglected incubator”

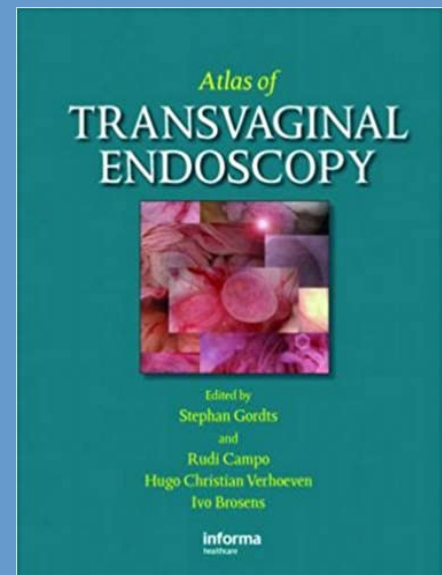
Do you think that even today we underdiagnose the adenomyosis?

I'm convinced that there is an underdiagnosis of adenomyosis in those patients coming to visit us for a fertility treatment. This is also a consequence of a mentality of a very liberal referral of patients to IVF



Dr. Stephan Gordts

Leuven Instituut voor Fertilititeit en Embryologie



programs lacking an accurate diagnosis and receiving the label of unexplained infertility. Even in absence of clear clinical signs as menorrhagia, dysmenorrhea and infertility, the presence of adenomyosis should be excluded in the elderly patients consulting after 2-3 failed IVF cycles. The IVF failure rates and miscarriage rates are higher in these patients. When diagnosing adenomyosis it is important to clearly define the lesion (diffuse, focal, cystic, JZ-pathology) to finely understand better the impact of these different lesions and to apply a correct treatment, hormonal or surgery.

What about the treatment of the adenomyotic cysts?

At this moment there are no clear data proving that removal of these cysts will improve pregnancy rates. Probably the impact of submucosal lesions can be more pronounced than the cystic lesions deeper in the intramural part. These cysts can be treated by an hysteroscopic approach in resection the cyst or by opening and coagulating the cystic wall using a bipolar probe. After treatment of such adenomyotic lesions, and this in contrast with the treatment of myoma, always a defect will be visible at control hysteroscopy. The underlying uterine pathology of increased uterine dysperistalsis, traumatizing the endomyometrial layer, enabling invasion and displacement of endometrial tissue, will not be solved by removal of these cyst. More research is required for a better understanding.

Is it adenomyosis more important in infertility than previously thought?

We are only at the beginning of recognizing the impact of adenomyosis on infertility with still a poor understanding of the pathophysiology. For many years adenomyosis was only a histological diagnosis obtained on the uterine specimens after hysterectomy. It is with the introducing of MRI and more sophisticated ultrasound that it became a clinical entity. Furthermore, adenomyosis is frequently associated with endometriosis where it then become difficult to distinguish which is impairing the fertility potential. It is still unclear if the adenomyosis which is occurring after a mechanical uterine trauma like a C-section or other uterine interventions has the same impact upon fertility than the spontaneous adenomyosis as a consequence of an underlying uterine pathology. Personally, I believe that the latter has a more pronounced impact upon fertility than previously estimated. Accurate diagnosis is important to help us in understanding this disease.

Can you tell us something about transvaginal hydrolaparoscopy (THL)?

We started to use this procedure systematically in the exploration of the infertile patient since 1997. It is a minimal invasive procedure allowing access to the pouch of Douglas with a simple needle puncture technique. Endoscopic visualization of the female pelvis remains an important examination to exclude pathology not detected at ultrasound like minimal endometriosis and tubo-ovarian adhesions. Standard laparoscopy is now frequently omitted in the fertility exploration because it is not an innocuous procedure for a pure diagnostic purpose. Recent published data demonstrate that in patients with the diagnosis of unexplained infertility, endometriosis was diagnosed in 30-50 % at laparoscopy. The THL offers us the possibility for an accurate diagnosis and treatment bypassing the difficulty and risks of a standard laparoscopy.

Do you have any advise for the young gynecologist who is starting in the world of minimally invasive surgery?

Yes, in the era of IVF there is still an important place for reproductive surgery because it can offer the patients the possibility for a spontaneous conception and for more conceptions when more children are desired. Reproductive surgery is in so far different from normal gynecological surgery as in the latter the diseased organ is removed, where reproductive surgery is trying to preserve as much as possible of the affected organ and to restore normal anatomy and all this is based upon microsurgical principles at laparoscopy and/or laparotomy. Training and education are in this context important. The temptation is high not to choose for the option of training in reproductive surgery but to choose for an easy way of IVF with less risks and better financial benefits. However helping patients in trying to achieve the highest possibility for a spontaneous conception, for me, is the correct way to go.

Original Article

Hysteroscopy Newsletter Vol 6 Issue 5

Hysteroscopic appearance of histiocytic endometritis in postmenopausal bleeding: a case report

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INTRODUCTION

Histiocytic endometritis OR xanthogranulomatous endometritis is characterized by disappearance of endometrial mucosa which is replaced by sheets of lipid containing histiocytic cells (foamy), siderophages, giant cells, fibrosis, calcification and polymorphonuclear leukocytes, plasma cells and polyclonal lymphocytes. This condition is very rare. Fewer than 25 cases have been reported worldwide [1].

Pathogenesis has been described to be inflammation due to post-menopausal cervical

stenosis or result of cervical carcinoma, which results in hematometra or pyometra.

Histiocytic inflammation is an unusual condition that involves kidney and gall bladder, which are subjected to chronic obstruction with subsequent infection. Involvement of the uterus is rare. Great awareness is needed as it can mimic malignancy with infiltration of myometrium or can be associated with malignancy.

Microscopic section shows fewer endometrial glands and sheets of lipid containing foamy histiocytes in stroma, along with diffuse infiltration by inflammatory cells (lymphocytes, plasma cells).

CASE REPORT

A 60 year old woman para 2 living 2 came with history of recurrent postmenopausal bleeding. Menopausal for 9 years

She gave a history of the first episode of postmenopausal bleeding 2 years after attaining menopause. Transvaginal sonography was done which revealed thin endometrium and she was treated expectantly.

Second episode of postmenopausal bleeding was reported after 6 years, transvaginal sonography showed 5-6mm thick endometrium and so she underwent dilatation and curettage.

Histopathology revealed benign endometrial hyperplasia and was managed conservatively. Third episode of postmenopausal bleeding was 1 year after the previous episode which lasted for 3 weeks

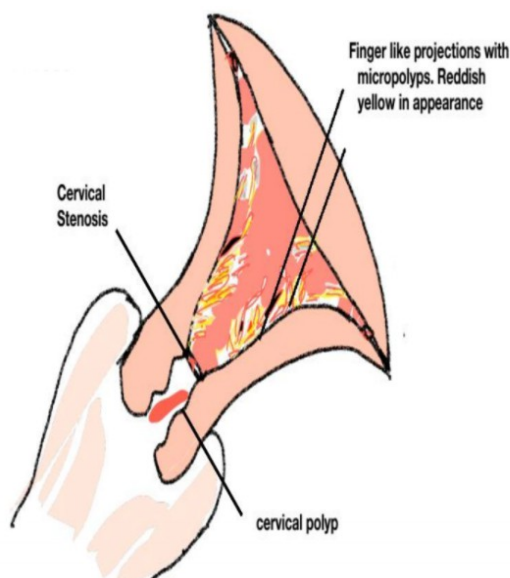


Figure 1: Hysteroscopic findings

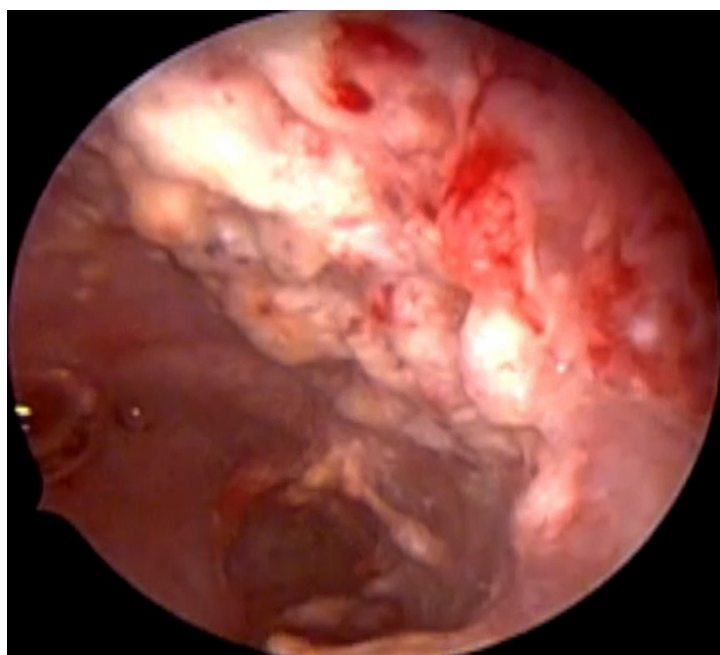
with on and off bleeding TVS showed a thick 8mm irregular partly echogenic endometrium.

On examination, pulse was 80 beats/min, blood pressure was 110/70mmHg. No comorbidities. BMI was 28kg/m², cardiovascular and respiratory system revealed no abnormality. Per abdominal examination revealed no abnormality. On per speculum examination, cervix and vagina were healthy.

Per vaginal examination revealed anteverted anteflexed normal size uterus. Fornices were clear. Mild tenderness was found on the uterus. Lab reports were normal. An office hysteroscopy done with 2.9mm 30 degree forward oblique Bettocchi scope (Karl Storz Tuttlingen) with normal saline as distension media and E.A.S.I endomat (Karl Storz Tuttlingen)

INTRAOPERATIVE FINDINGS

On hysteroscopy a polyp was removed with a grasper. Stenosis at internal os was opened with crocodile grasper and 5Fr scissors with cuts at 3-9 o'clock. Yellowish scattered finger like projections with calcification seen with micropolyps. on posterior wall and left lateral wall with ant wall showing endometrial hyperplasia and fundal region showing hyperemia (Figure 1). Multiple biopsies were taken from the finger like projections from the base of these growths. Macroscopic appearance was suggestive of carcinoma endometrium with endometritis due to presence of micropolyps. (Figure 2 & 3)



HISTOPATHOLOGY

Histopathology revealed cystic glandular hyperplasia with mild focal atypia on background of histiocytic endometritis. (Figure 4, 5, 6). Endometrial biopsy revealed no frank malignancy. Benign endocervical polyp was found with no atypia.

Owing to the history of third episode of postmenopausal bleeding, the patient was advised hysterectomy with bilateral salpingo oophorectomy. Histopathology was negative for carcinoma endometrium

DISCUSSION

Some interesting data regarding this entity:

- The first case was reported by Barua et al in 1978 [3]. (Table no.1)
- Kim and Lee in 2002 described cases of nodular histiocytic hyperplasia which is a variant of Xanthogranulomatous endometritis [4].
- In 2006 Noack et.al reported 1 case of XGE with lethal outcome [5].
- In 2007 Dogan-Ekici and Usubutum et.al reported one case mimicking endometrial carcinoma [6].
- Buckley and Fox in 1980 coined the term histiocytic endometritis [7].
- Malakoplakia is another variant of HE, which shows Michaelis -Gutmann bodies [8].

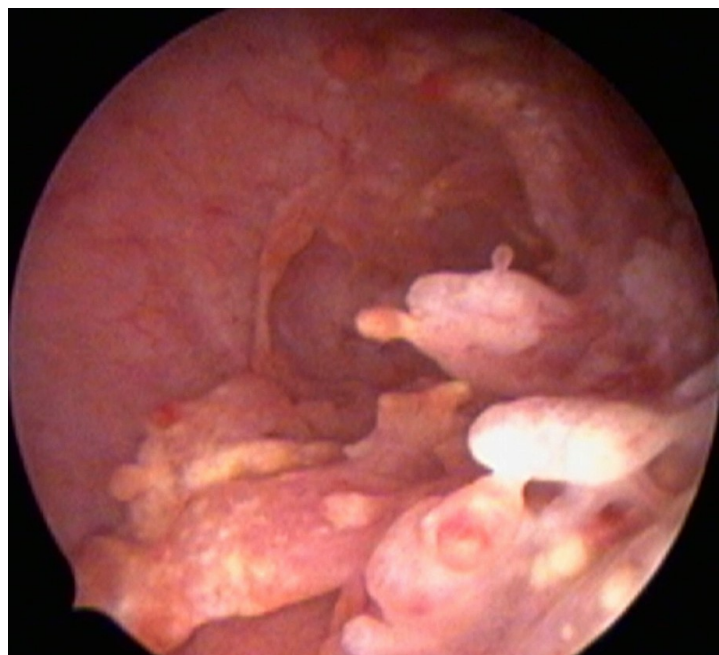


Figure 2 and 3: Yellowish scattered fingerlike projections with calcifications

- Many of the cases reported were associated with carcinoma endometrium. The micro organisms isolated were E.coli and P.vulgaris [2].

1978	Barua et.al	1	E.coli and P.vulgaris
1980	Buckley and Fox	2	No bacteria
1983	Ashkenazy et.al	4	
1985	Pounder and Iyer	1	
1989	Blanco et al	1	
1990	Russack and Lammers	6	
1996	Rivas and Phillipe	2	
2006	Noack et.al	1	Enterococcus & P Magnus
2007	Dogan-Ekici and Usubutum et.al	1	No bacteria
		Total	
		19	

Presence of histiocytic endometritis does not rule out malignancy and requires extensive sampling to rule out foci of neoplastic growth.

Histiocytic endometritis is associated with Endometrial carcinoma or cervical cancer. If no malignancy is found, then treatment will require correction of cause.

Two types of histiocytes may be seen, namely foamy which are associated with hyperestrogenic lesions including endometrial hyperplasia and carcinoma and xanthogranulomatous endometritis. The foamy histiocytes contain single or multiple cytoplasmic vacuoles and dark small nuclei and can be positive for estrogen and progesterone receptors. They are aggregated or loosely scattered in endometrial stroma. The second type of histiocytes resemble Langerhans cells. They are not associated with endometrial hyperplasia or endometrial carcinoma. They are immunohistochemically positive for CD68 and lysozyme.

Xanthogranulomatous endometritis shows granulomas composed of histiocytes, other inflammatory cells and cholesterol clefts.

Clinically, preliminary diagnosis is of carcinoma endometrium or hyperplasia. Xanthogranulomatous endometritis is similar both in macroscopic and microscopic appearance to xanthogranulomatous change occurring in other organs such as kidney and gallbladder.

There is replacement of endometrium and sometimes invasion of myometrium by friable yellowish tissue composed of histiocytes, mimicking carcinoma endometrium and so is important for clinicians and pathologist. Coexistence of endometrial carcinoma with xanthogranulomatous endometritis is important. The foamy histiocytes infiltrating the myometrium might be misdiagnosed as

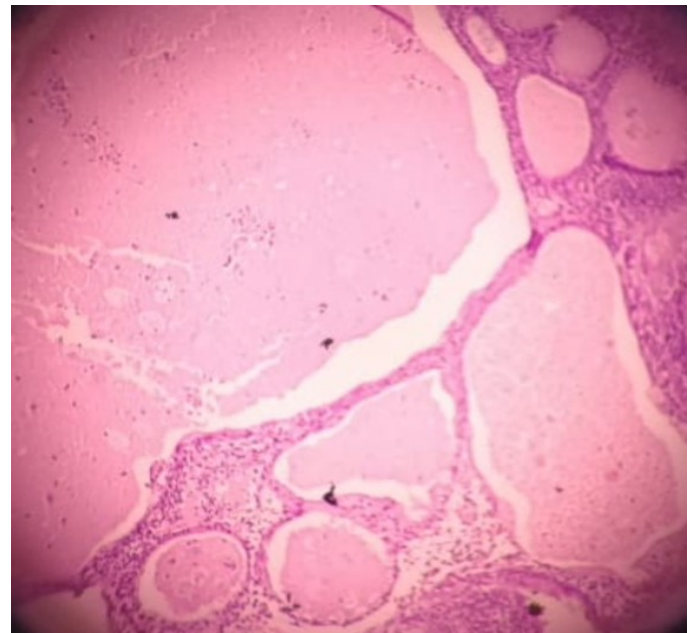


Figure 4: Cystically dilated glands

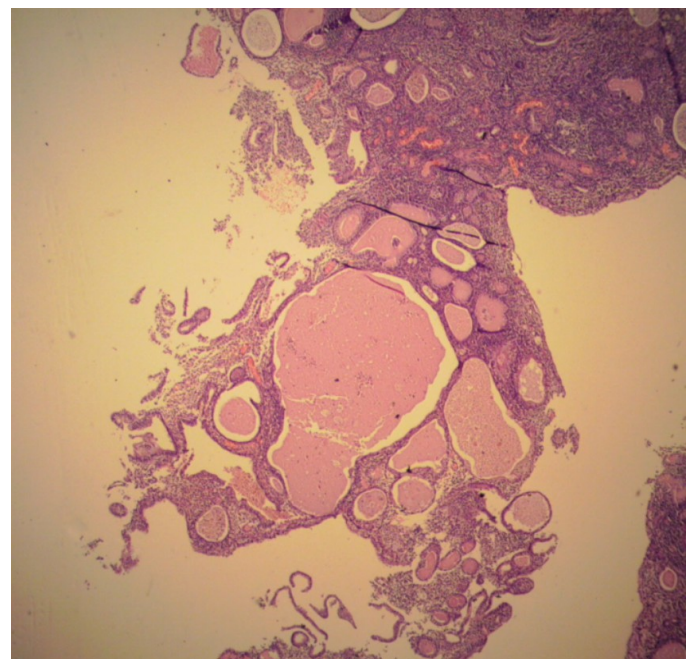


Figure 5: Foamy histiocytes adjoining the tissue border

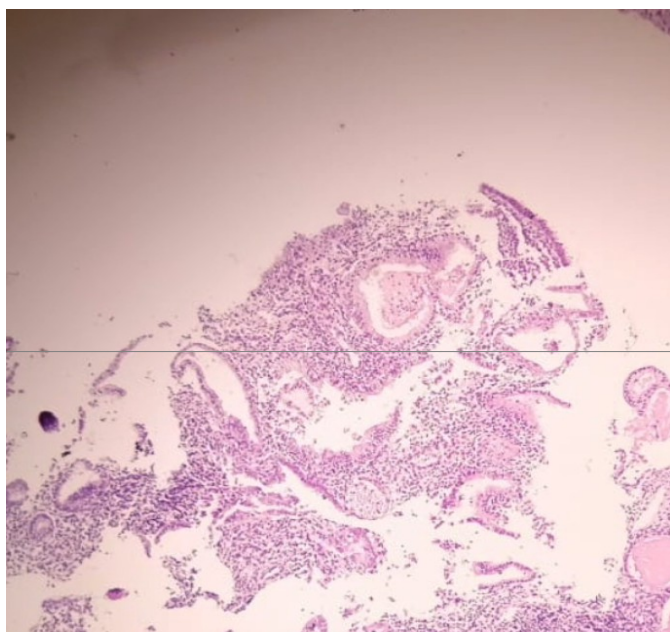


Figure 6: Foamy histiocytes adjoining the tissue border

clear cell carcinoma or sarcoma which can be resolved by cytological and immunohistochemical detail.

The development of xanthogranulomatous endometritis may be influenced by various factors, including tumor bulk, death of tumor cells due to radiation or necrosis, abundant amount of haemorrhage and cervical stenosis or preexisting vascular compromise such as arteriosclerosis.

Differential diagnosis include malakoplakia. In malakoplakia there are intracellular and extracellular laminated inclusions called calcospherites or Michaelis- Gutmann bodies and special foamy histiocytes called von Hansemann cells. Malignancy is another differential diagnosis. Carcinoma of endometrium and cervix can be associated with this.. So exhaustive sampling is necessary.

Majority of these cases resolve spontaneously or after antibiotic treatment. If untreated can lead to systemic inflammation. Surgery forms mainstay of treatment.

In our case, we clinically suspected carcinoma and on hysteroscopy, the appearance was similar to carcinoma with endometritis seen as micro polyps. The probable reason for endometritis could be haematometra with on and off bleeding for 3 weeks in the third episode. It is important that targeted biopsies should be taken with good amount of tissue from the base as if removing small polyps.

CONCLUSION

Histiocytic/ xanthogranulomatous endometritis is a condition which can mimic malignancy. Owing to their rarity and the scant data available, exhaustive sampling is necessary for further management and follow up

ACKNOWLEDGMENTS

We hereby acknowledge that all authors have contributed equally to the paper.

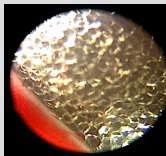
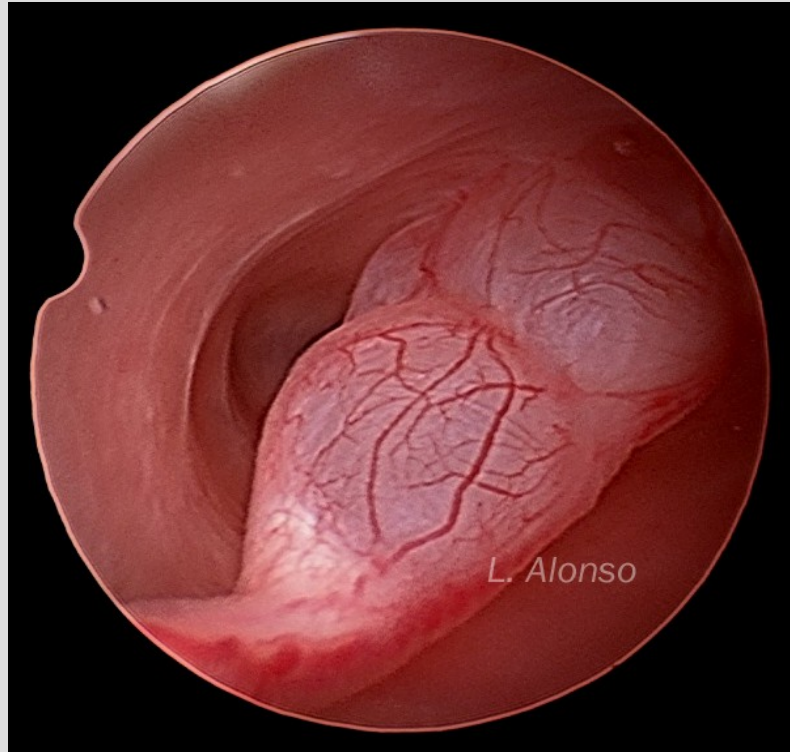
DISCLOSURES

This paper has not been presented at any conference or published in any journal till date. The authors declare that they have no conflicts of interest and nothing to disclose. Source of funding: None

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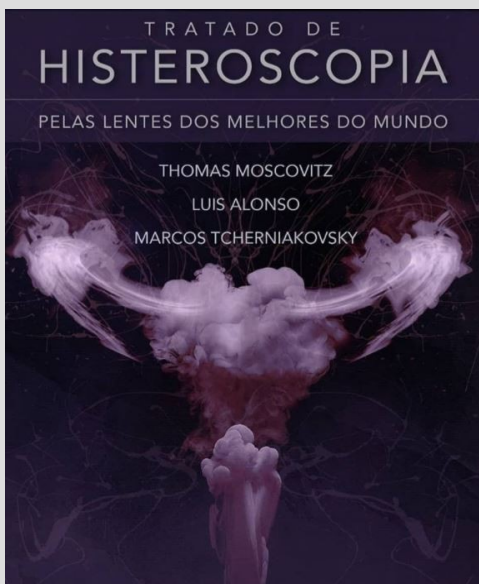
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What's Your Diagnosis?



Answer to the previous issue

Epiploic Fat



TRATADO DE HISTEROSCOPIA

**Thomas Moscovitz, Luis Alonso and Marcos
Tcherniakovsky**

Dilivros 2020

Case Report

Hysteroscopy Newsletter Vol 6 Issue 5

Embryoscopy of fetal malformation: Case report of a triploidy and syndactyly

Authors: Artazcoz, S.^{1,2,3}, Wachowicz, S.², Gonzalez, A.M.¹, Nicotra P.³, Hamer J.³

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INTRODUCTION

Embryoscopy is a procedure which can be used for the diagnosis of structural malformations of embryos after failed pregnancies allowing to obtain biopsies for genetic analysis. There is evidence of inaccurate genetic results due to maternal contamination of abortion material obtained by curettage or aspiration; including results of normal karyotypes in embryos with visible macroscopic malformations. This determines the importance of the embryoscopic study in failed pregnancies to facilitate the understanding of the etiology of spontaneous abortions.

CASE REPORT

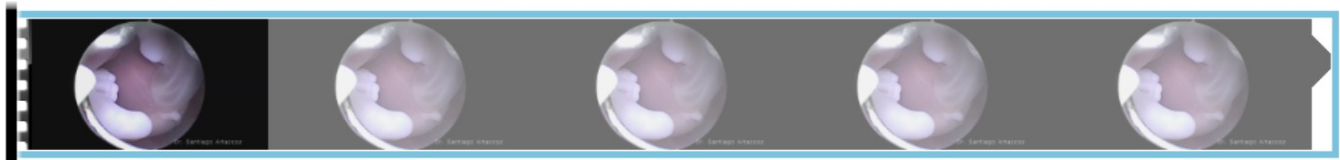
We present a case of a female 29 years old patient with an ultrasound diagnosis of a 10.5-week missed abortion. The procedure was performed under general anesthesia: Hysteroscopy with normal saline solution revealed: Cervical canal without alterations, uterine cavity: without associated pathology, visualization of a gestational sac with implantation on the anterior

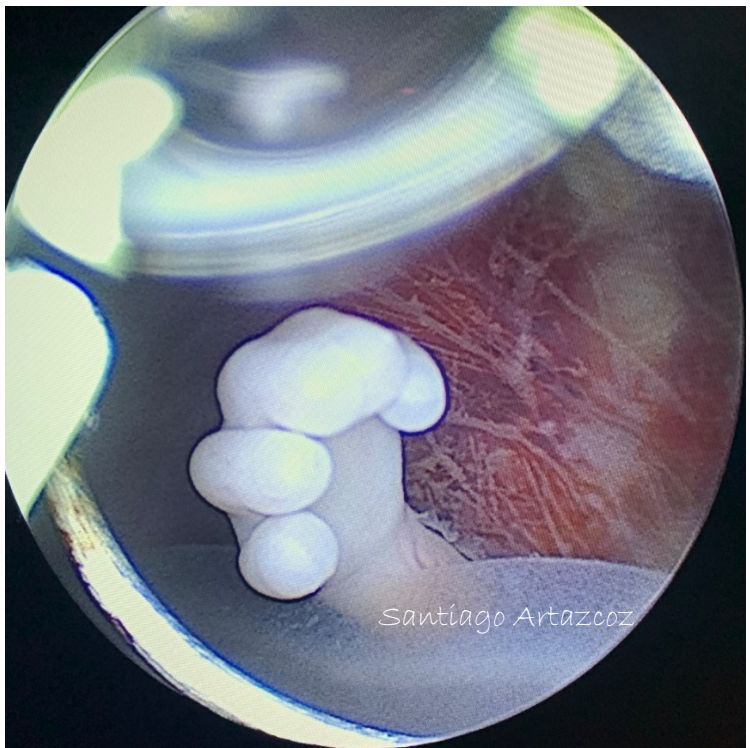
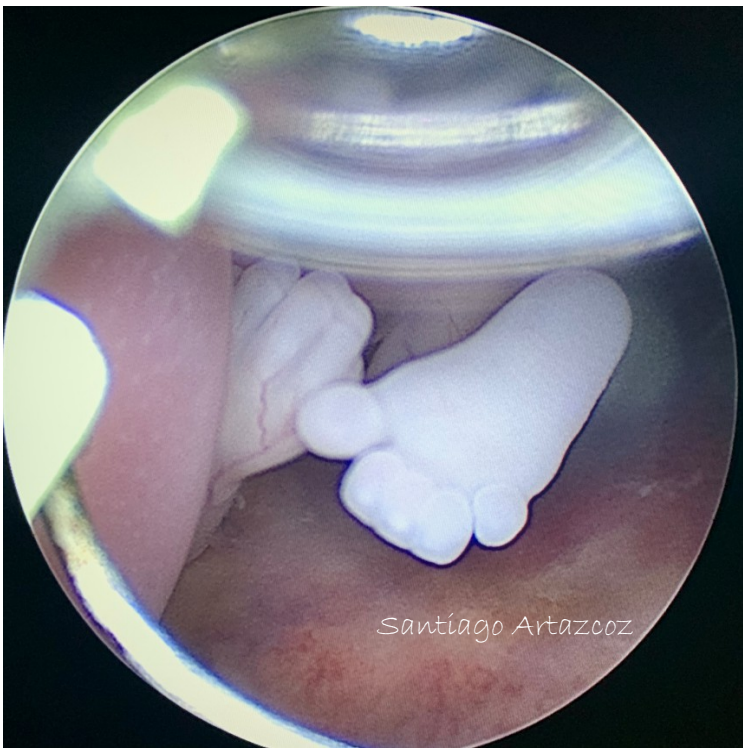
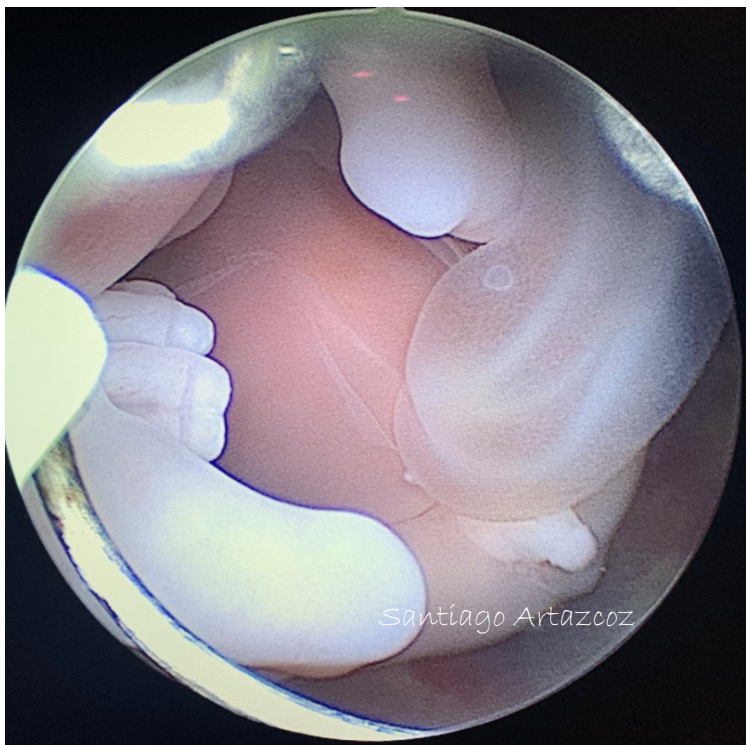
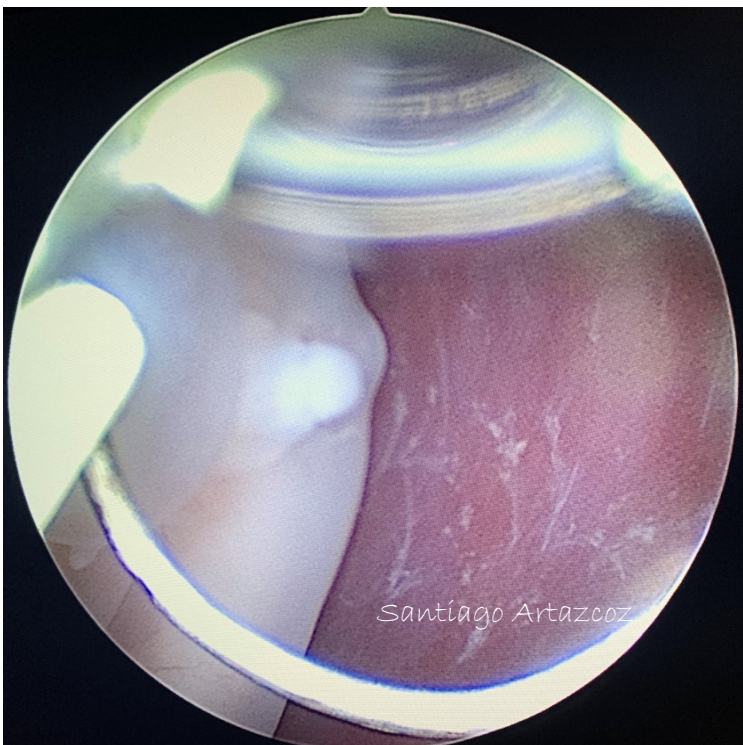
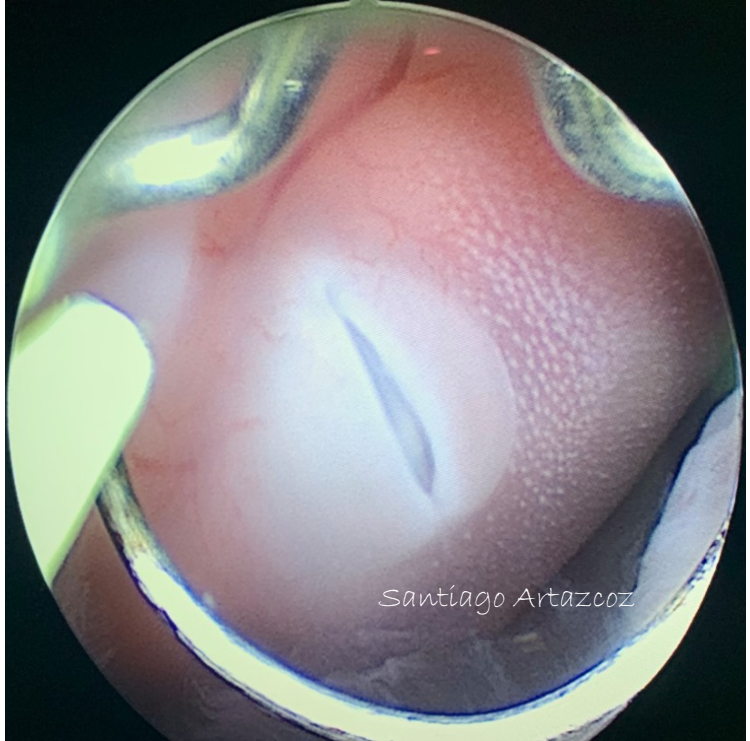
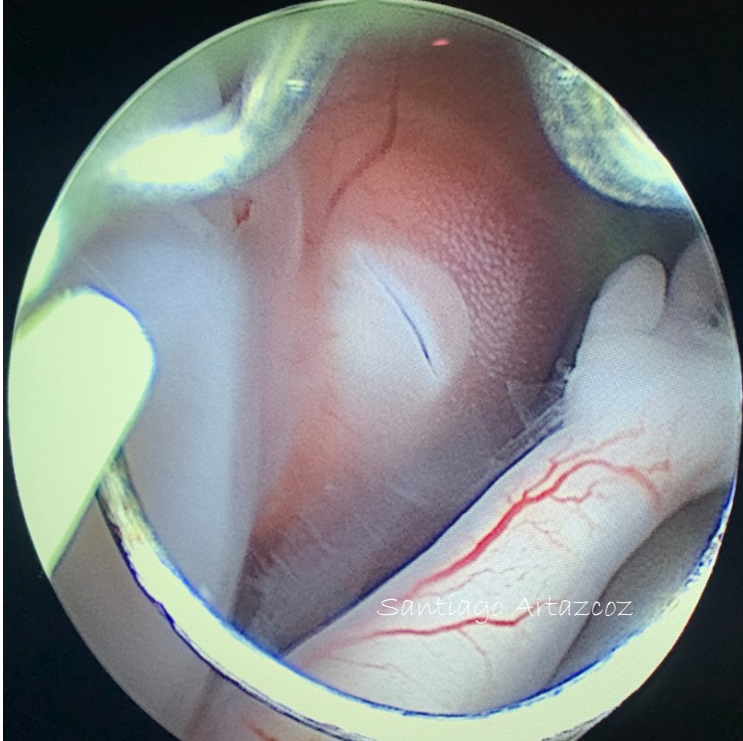
uterine wall. Opening of the same and the amnion revealed the presence of a single male embryo, of approximately 40mm in length, syndactyly in both upper hands and in a lower extremities, signs of hydrocephalus. Multiple direct biopsies of the embryo and trophoblast were collected and sent for genetic study, and uterine evacuation was performed under direct visualization. Molecular karyotype (NGS technique): Triploidy. XXY. Type II or Diagenic triploidy is suspected due to presenting alterations in the hands, feet and head.

CONCLUSION

Embryoscopy allows the identification of morphological fetal alterations with very good image definition. This procedure can be performed by trained hysteroscopists and no specific hysteroscopic instruments are required. Unlike the sample obtained by curettage or uterine aspiration, the direct biopsy of the embryo and trophoblast by hysteroscopy was shown to reduce the risks of maternal contamination and thus improve the sensitivity of the genetic study.

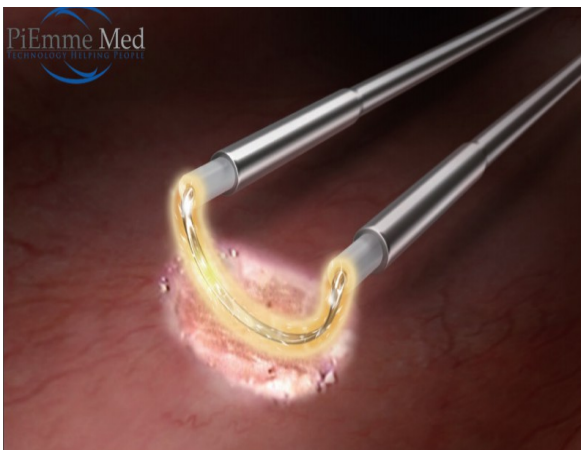
[CLICK TO WATCH THE VIDEO](#)





HYSTEROSCOPY DEVICES

Plasma-kinetic radiofrequency system



Plasmacycline RF technology moves gynecological resection higher than traditional bipolar technology

Plasmacinetic energy reduces thermal damage as it operates at lower temperatures

The ARS800 Plasmacycline RF Resection System allows the treatment of both small intracavitary diseases in Office Hysteroscopy with Ø5Fr electrodes, and of medium-severe pathologies with the resectoscope



More information at <https://www.piemmemed.it>

Update

Hysteroscopy Newsletter Vol 6 Issue 5

ISTMOCELE SURGERY

Luis Alonso. Málaga. Spain

INTRODUCTION

The hysteroscopic isthmocele surgical correction technique was first presented in 1996 by E. Fernández, C. Fernández and C. Fabres at the 25th annual AAGL congress in 1994. Since that first presentation, the technique has been modified over the years, although it has continued to maintain its original essence. The modifications that have emerged have been the result of a better understanding of the pathophysiology of isthmocele and have been aimed at improving the symptoms related to the scarring defect of the previous cesarean section.

In this review we will address the current surgical techniques and the different proposed approaches, in addition, we will describe the technique as it is conceived today and how it has evolved since its first presentation 23 years ago.

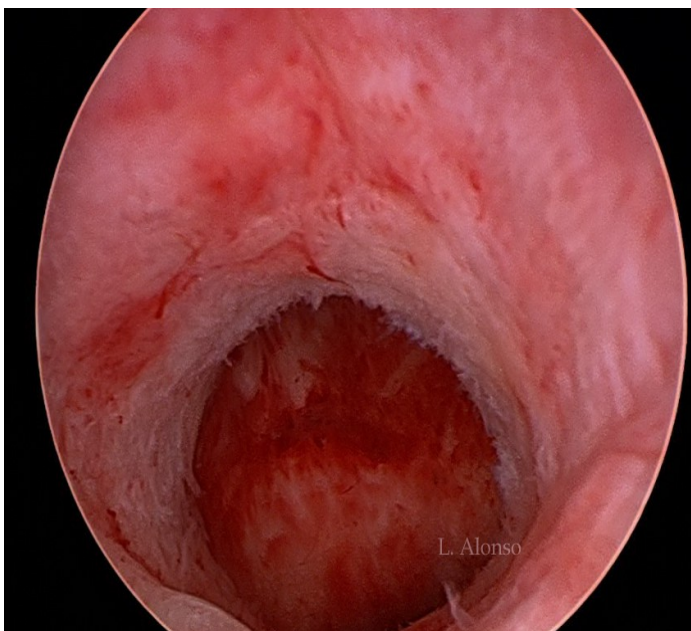


Figure 1. Hysteroscopic view of the isthmocele

Secuelas tardías de la Cesárea

Por Eduardo García-Triviño
 Director de la Maternidad Provincial de Jaén (1)

Señores:

Sería obvio razonar sobre el hecho de que en la Obstetricia actual, y salvo la distocia del Período basal, la Cesárea ha desplazado a la Torgura clásico o, al menos, ha relegado sus operaciones al orden de lo excepcional. Son los índices de mortalidad y de morti-natalidad, con sus ínfimos valores actuales, los que basamentan este criterio que es universal. Como universal es el deseo de restringir operaciones y la convicción de que ello será posible cuando un mejor conocimiento de la fisiopatología de la Distocia Funcional (fuente de muchas indicaciones de cesárea), y una Farmacología más efectiva de dicha disfunción, estén logrados. Ya está dando sus frutos en esa ruta la Conducción Médica del parto (que encausa muchas disritmias primarias) y que tuviera sus precursores en Kreis y Schikele, en Es-

trasburgo, hace ya 40 años, cuando afirmaban que la medicación analgésica y espasmolítica era la mejor medicación occitócica del Período dilatante. Pero aún queda mucho camino por recorrer hasta controlar del todo el "motor del parto". En tanto, habrá que seguir considerando a la Cesárea como operación de muchas indicaciones, incluso, de liberales indicaciones, dada su seguridad actual.

Por la liberalidad de las indicaciones de la Cesárea, por su frecuente uso, la Cesárea sigue siendo motivo de preocupación para el Obstetra. Ciertamente que ya no nos preocupa la mortalidad, que pertenece a época rebasada. Los perfeccionamientos de la técnica de la operación, de la técnica quirúrgica general, del advenimiento de los antibióticos, nos permiten hoy afirmar que una mujer cesareada sin más problemas que su distocia,

(1) Conferencia en el Curso de Actualizaciones Médico-Quirúrgicas. Seminario Médico. Curso 1967-68.

HISTORY OF ISTHMOCELE SURGERY

In 1968 during a conference in a medico-surgical update course, Dr. Garcia Triviño, medical director of the Maternal Hospital of Jaen presented his knowledge on what he named a late sequela of cesarean section. During it, he spoke of pathological healing, consisting of a myometrial continuity defect at the isthmus level and which was diagnosed by performing a hysterosalpingogram performed 4 months after the cesarean section. Those women who had it underwent the test again at 12 months, to see if the defect had healed. In those cases in which the defect persisted, an elective cesarean section was recommended in case of a subsequent pregnancy.

As we have already commented in the introduction, the first existing reference on surgical remodeling of the scar defect dates from 1996, just one year after Morris described the correlation between the healing defect and the presence of menorrhagia, abdominal pain, dyspareunia and dysmenorrhea, which has been termed by many as the cesarean scar syndrome or Morris syndrome [1]

This first published work is due to Dr. Emilio Fernández and was presented as a communication at the 25th congress of the AAGL. This first series consisted of 20 patients, of whom hysteroscopic surgery was performed in 7 of them. The technique they used was the resection of the ring of fibrous tissue located in the lower part of the cesarean section scar. Of all the operated patients, four also suffered from secondary infertility; after the intervention, two of these patients spontaneously conceived. This first publication concluded that hysteroscopic resection of this fibrous ring improved postmenstrual bleeding in these patients [2].



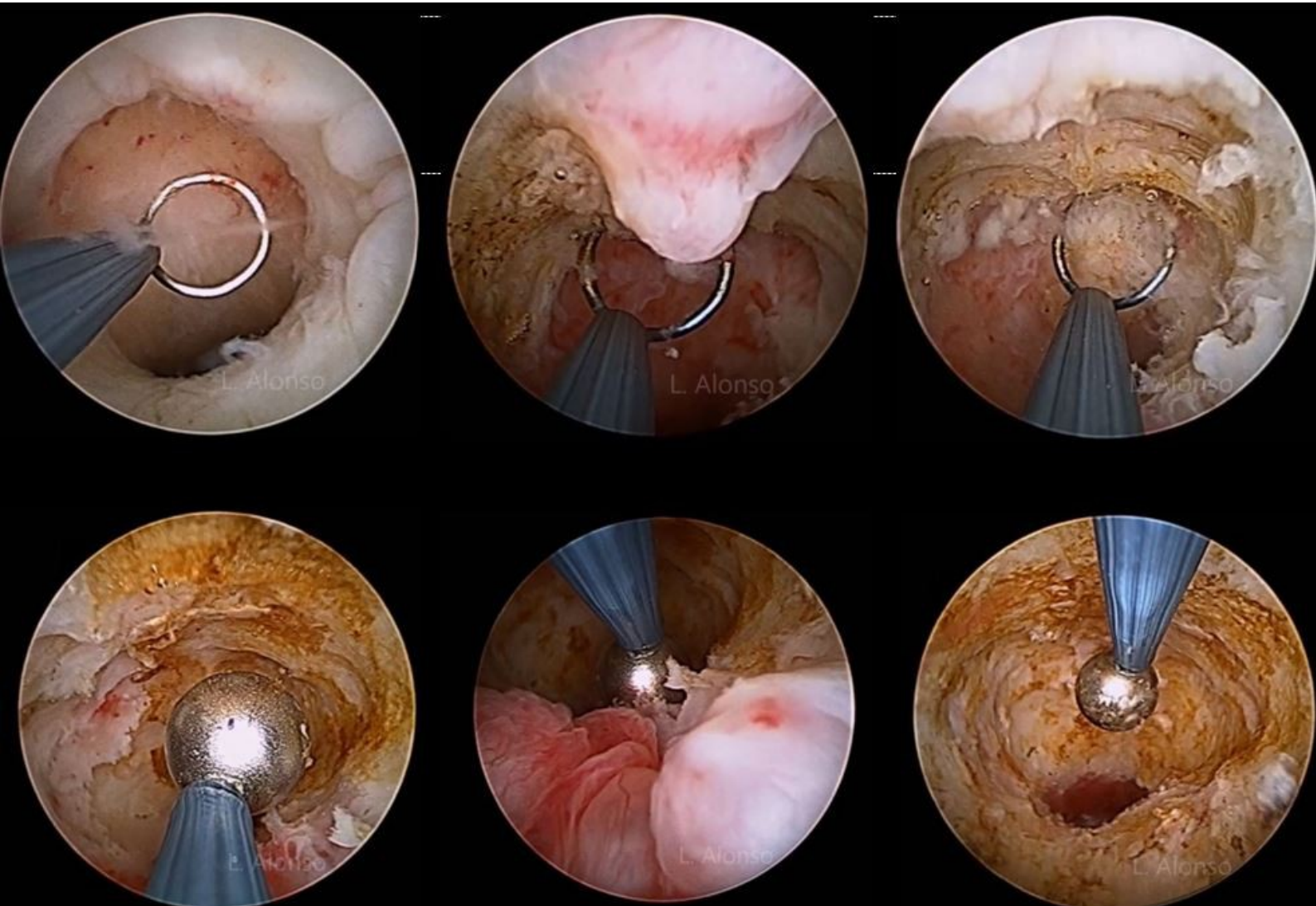
Cecilia Fabre



Giampietro Gubbini

This postmenstrual bleeding that was produced by the existence of retained blood at the level of the scar, could be responsible for secondary infertility by interfering with the quality of cervical mucus.

It was not until 2005 when Dr. Cecilia Fabre from the Las Condes Clinic in Santiago de Chile



published her first work in which 24 patients with postmenstrual bleeding were included and in which the presence of any other intrauterine pathology as the cause had been ruled out. In these patients, a resection of the fibrous tissue located at the lower level of the scar was performed, as well as the fulguration of the endometrial glands and the blood vessels located at the bottom of the isthmocele.

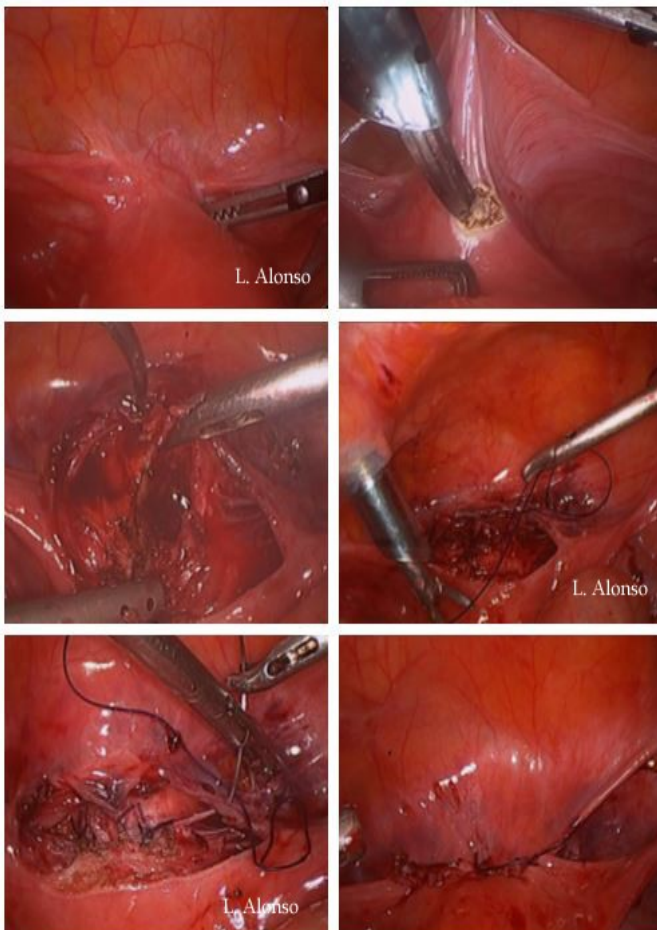
Several years later, Dr. Giampietro Gubbini published his first series of 26 patients in which he performed resection of both the proximal and distal fibrous ring, completely flattening the healing defect and also performing an electrofulguration of the base with a rolling ball [3]. Years later, Gubbini himself proposed carrying out a 360° electrofulguration by means of which the aim was to destroy both the congestive tissue at the bottom of the isthmocele and the surrounding inflammatory tissue. This inflammatory tissue is usually located on the posterior aspect of the cervical canal and appears as a consequence of the irritation produced by the hematic accumulation located in the isthmocele.

The first reference to the combined laparoscopic and vaginal approach dates from 2005 and was presented by Petra Klemm [4]. In this study, they corrected the defect using both routes in three patients in which the bladder was dissected laparoscopically and the isthmocele was sutured vaginally. This is the first reference that exists of a reparative or corrective technique for isthmocele. Reparative techniques are those in which the existing healing defect is corrected and sutured, restoring the normal anatomy of the uterine isthmus.

Finally, it was Donnez who described the technique using exclusively the laparoscopic approach for isthmocele correction [5]. It is also a reparative technique that aims to achieve the integrity of the anterior wall of the uterine segment by re-suturing the defect related to a defective healing of the anterior cesarean section.

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Original Article

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All In One office management for Retained Products of Conception

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The "See and Treat" concept was born long time ago, however, it remains up to date now a logic, fast, safe and low cost procedure. It takes place out of the operating room "OR" in dedicated offices without any stay at the hospital before or after the procedure. (1)

Mastering this technique out of the OR and most of the time without any anaesthesia may need more skills and knowledge than what we have seen with patients managed in the OR and under anaesthesia because we are dealing with very small instruments in order to manage different kinds of intrauterine pathologies with great similarities as it is performed in the OR. That in fact was more challenging in the beginning (2).

Another fact is that most of the time we cannot do office hysteroscopy without performing an Ultrasound scan in order to know what we are looking for. Gynaecologists skilfully master the ultrasound exams which gives them a certain liberty, furthermore we are assisting an amazing development of the ultrasound machines which equipped them with better opportunity to get the possible diagnosis in a small amount of time especially when it is combined it with some useful techniques as SIS (saline infusion sonography) (3)

Aforementioned arguments the combination at the same time from some obvious symptoms for some intrauterine pathologies at a specific time in the women cycle. Can remains the right diagnosis since the first time. In addition to the power of

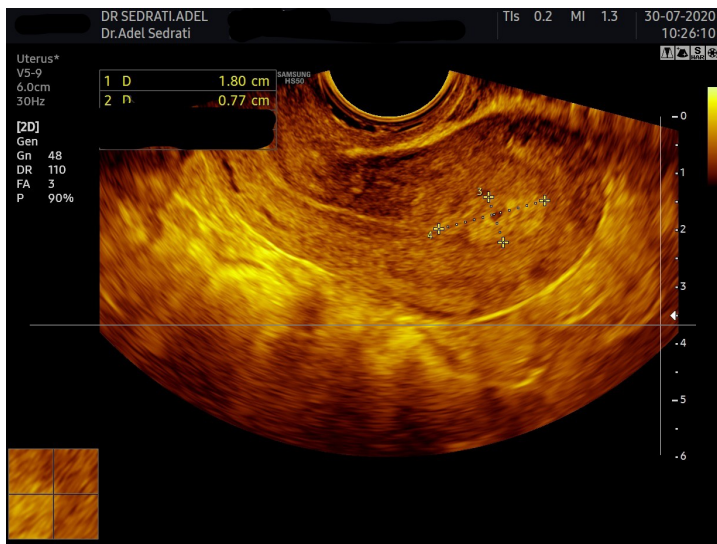


Image 1: 2D vaginal ultrasound scan shows a placental remnant

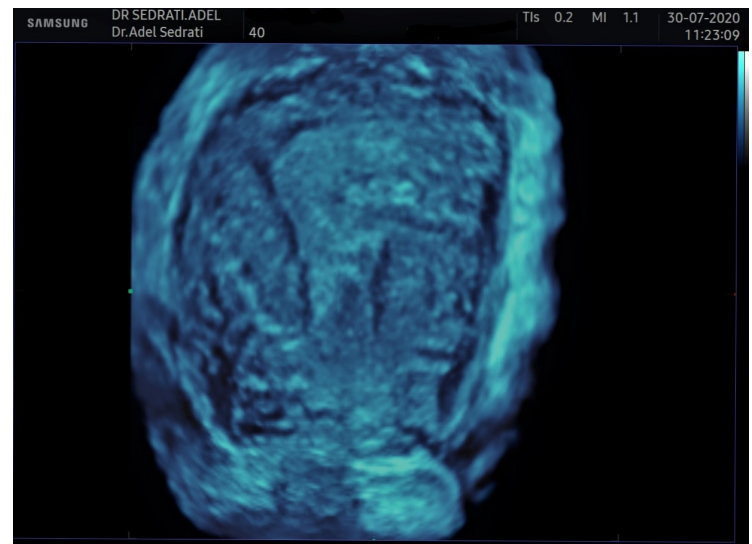


Image 2: 3D vaginal scan shows a suspicious placental polyp

hysteroscopy to be used in order to verify this diagnosis as well as to treat it. As such the result will be from the symptom we can have a diagnosis by looking at the story of this patient and doing a clinical exams. Following most of the time by a vaginal 2D and 3D ultrasound scan. Furthermore hysteroscopy allows as to see “confirm” and treat this intrauterine pathology. That concept opens the door for some obvious intrauterine pathologies to be managed from the symptom to the therapy in only one office session. That may constitute the evolution Of the see and treat concept and the management of some intrauterine pathologies.

CASE REPORT

A married women of 38 years old with a story of caesarean section since 52 days, she had a small amount of continuous vaginal bleeding. The clinical exam showed only an intrauterine bleeding. A 2D (image 1) and 3D (image 2) vaginal ultrasound (VUS) scan revealed clearly images of suspicious placental polyp of 18mm over 07 mm at the lateral left wall close to the ostia of the same side. Type 0 because no vascularisation has been seen while the Doppler was performed. The patient was asked to have an office hysteroscopy after a well explanations. This last one was performed and showed a clear aspect of type 0 placental polyp (image 3) at the exact place as described before with VUS scan, there wasn't any other intrauterine pathologies according to the diagnosis hysteroscopy part, at that time a grasper of 5Fr was passed through the operating channel of BETTOCCHI 05 mm hysteroscope realised a successful ablation of this placental polyp (image 5) sent to the histology later. The procedure was painless, finished without any complication in a short time and the patient was satisfied.

This so called ALL IN ONE office management from the symptom to the therapy for certain intrauterine pathologies is only the result of the hysteroscopy and ultrasound strategies mastered by the same gynaecologist.

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Image 3: hysteroscopic aspect of placental polyp

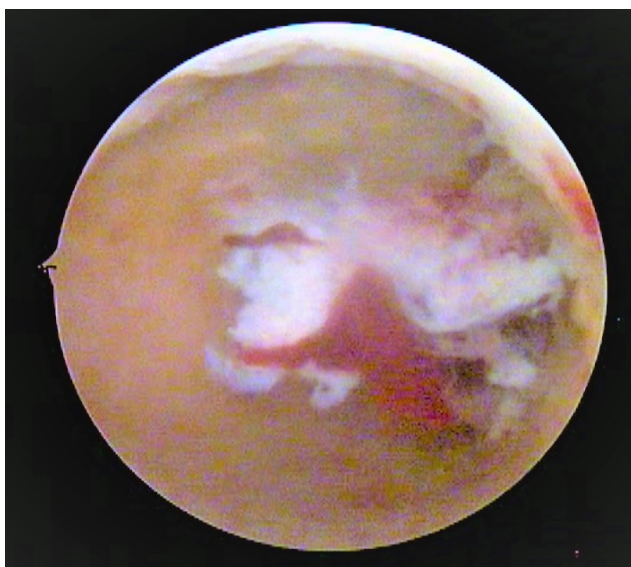


Image 4: Removing placental polyp

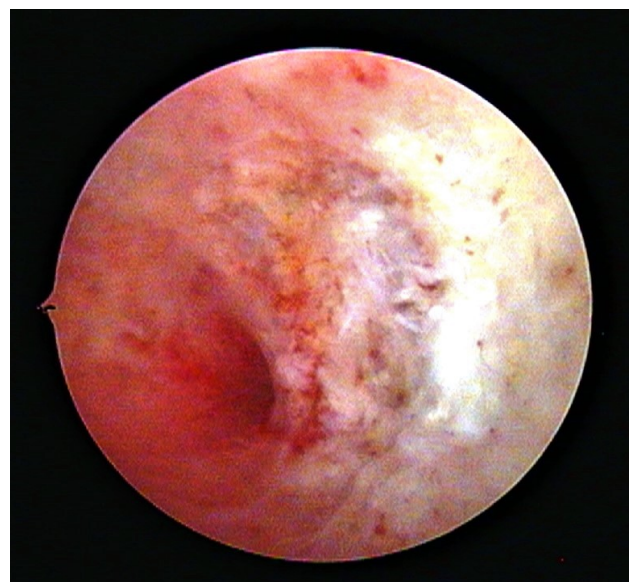


Image 5: Final aspect

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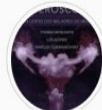
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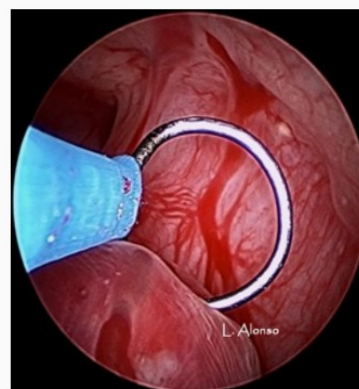
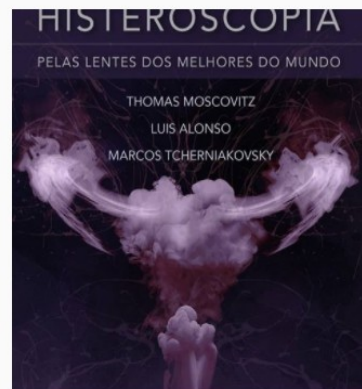
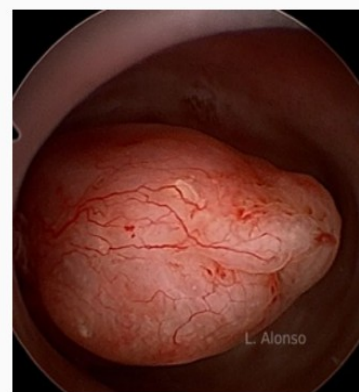
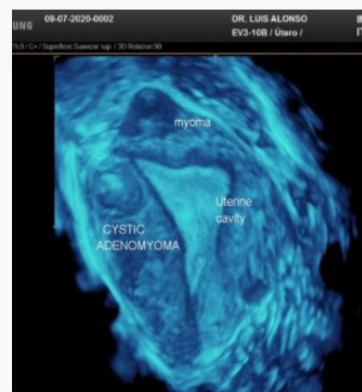
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