

C. Panayotidis · R. Ranjit

An unusual case of Asherman's syndrome in a virgin menopausal woman

Published online: 5 February 2004
© Springer-Verlag Berlin / Heidelberg 2004

Abstract We present here a case of Asherman's syndrome in a 52-year-old menopausal woman referred to our clinic for postmenopausal bleeding. This case demonstrates a very unusual combination of postmenopausal intrauterine adhesions and ovarian tumour.

Keywords Intrauterine adhesions · Asherman's syndrome · Synechiae

Introduction

This case of Asherman's syndrome involved a 52-year-old menopausal woman referred to our clinic for postmenopausal bleeding. This case demonstrates a very unusual combination of postmenopausal intrauterine adhesions and ovarian tumour.

Case report

A 52-year-old menopausal woman was referred by her GP to the gynaecological clinic for post-menopausal bleeding. She had been menopausal for 5 years with no previous gynaecological or medical history. She was not on any HRT, and she did not have a history of tuberculosis. This woman was also a virgin.

It was difficult to examine this woman vaginally; therefore an urgent diagnostic hysteroscopy with D&C was organised. She was examined under general anaesthesia. No abnormalities were noted on her vulva. The hymen was intact and complete. With a very small (virgin) speculum, the cervix was visualised. The cervix was small with healthy appearance; no bleeding or signs of atrophic cervicitis were seen. Using a small grasp forceps the uterine sound (hysterometre) was passed through with great difficulty. Brown discharges and old dark blood came from the cervix. Haematometra was suspected. The uterus was bulky; no adnexal or other mass were palpated.

The hysteroscopy demonstrated a surprising amount of intrauterine adhesions, synechiae (Fig. 1). It was not possible to visualise

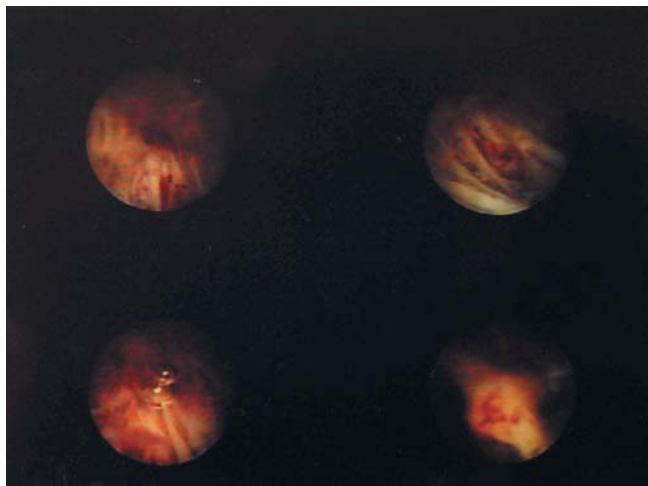


Fig. 1 Four images of hysteroscopic view. Intrauterine adhesions



Fig. 2 After total abdominal hysterectomy and bilateral salpingo-oophorectomy: uterus adnexa, benign ovarian cystadenoma

C. Panayotidis (✉) · R. Ranjit
Department of Obstetrics and Gynaecology,
Torbay Hospital South Devon NHS Trust,
Rorquay, TQ2 7AA, UK
e-mail: costapan@hotmail.com

the ostiums, and no other distinguished structure could be seen. Curettage was attempted, and scanty samples were obtained for histology. An urgent ultrasound scan was performed and the uterus was found to be 7 cm in length and 2.5 cm in depth; the endometrium was thickened (measuring 9 mm). The left ovary had a normal appearance and measured 2.5 cm. On the right adnexa there was a cystic septated mass of 10 cm that did not have the appearance of a simple cyst. No free fluid was seen in the pelvis, and the level of CA125 was within the normal range. An urgent total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed. The histology demonstrated an ovarian cyst of benign mucinous cystadenoma. Concerning the uterus, the endometrium had cystic changes and some benign polypoid formations could be detected (Fig. 2).

Discussion

Asherman's syndrome or uterine synechiae are adhesions within the uterus such that the uterine walls adhere to one another and the cavity becomes partly obliterated. Also, the endocervical canal may be affected. In the above case no particular symptoms were noticed, and the initial management for the intrauterine adhesions led to the diagnosis of a right ovarian benign tumour, which was also asymptomatic. This case is a very unusual combination of postmenopausal intrauterine adhesions and ovarian tumour.

Risk factors

In most cases, synechiae are due to endometrial trauma during pregnancy, such as postpartum (for evaluation of the uterus) or postabortal (curettage D&C, which is performed following a miscarriage), or mechanical evacuation of a live or dead foetus [1]. Curettage after a missed abortion is also a relatively frequent cause of adhesions. Rarely, curettage in a non-pregnant uterus results in adhesions.

Adhesions can also result from after other types of uterine surgery such as intrauterine surgery to remove fibroids, uterine structural defects (septum, bicornuate uterus and large polyps) and infections related to intrauterine device (IUD) use or after caesarean section [2]. Less commonly, these adhesions can also be associated with prolonged use of an IUD or the placement of any foreign object within the uterine cavity.

Apart from trauma and infection, chronic endometriosis and prolonged rupture of membranes during pregnancy can also be implicated. In rare cases, other infections such as tuberculosis and schistosomiasis may be related with intrauterine adhesions. These infections are rare in Europe, and uterine problems related to these infections are even more rare. Radium insertion into the uterus for the treatment of gynaecologic cancers can lead to Asherman's Syndrome.

Most common symptoms are: primary amenorrhoea, secondary amenorrhoea (accounts for 1–2% of cases), decreased menstrual flow, infertility and recurrent miscarriages. Endocervical adhesions can present as a cyclic pelvic pain as a result of haematometra.

Complementary examination for diagnosis

The pelvic examination does not show any abnormality. Some times during hysteroscopy the diagnosis may be suspected when it is difficult or impossible to pass a uterine sound into the uterine cavity. If Asherman's syndrome is suspected, hysterosalpingogram or hysteroscopy is the first line investigation (outpatient clinic). These tests could reveal scar tissue partially or completely obstructing the uterine cavity.

The hysterosalpingogram can reveal multiple filling defects and persistent filling defect of variable size in the endometrial cavity, and in advanced cases the endometrial cavity becomes irregular and deformed. Ultrasonography or hysterosonography could give valuable information [3].

Treatment

Asherman's syndrome should be treated if it is causing infertility or amenorrhoea in young patients. Curettage is necessary for menopausal women if bleeding occurs in order to exclude endometrial malignancy [4].

Treatment is effective in about 60% of cases. Radical surgical treatment performed by hysteroscopy includes electrocautery or laser dissection and removing adhesions or scar tissue within the uterine cavity [5].

After excision the uterine cavity must be kept open while it heals to prevent recurrence of scar tissue. An intrauterine balloon, intra-uterine device or a paediatric Foley catheter for 4–8 weeks is left in situ, and two cycles of combined oral contraception are given to aid endometrial regeneration [6]. A short course of steroid, for example, 20 mg dexamethasone i.m. every 4 h for 36 h is also suggested.

If tuberculosis or schistosomiasis infections are detected, appropriate antibiotic treatment will be necessary.

Prognosis

We cannot predict why or how intrauterine adhesions are formed, but their existence is an uncommon problem. It may be less common if prophylactic antibiotic treatment is given when a D&C is performed. These can be cured in most women with surgery, although sometimes more than one procedure will be necessary. Approximately 70–80% of women who are infertile because of Asherman's syndrome will have a successful pregnancy after treatment [5]. Patients with severe adhesions or extensive destruction of the endometrial lining may only have full-term pregnancy rates in the 20 to 40 percent range after treatment. It is the volume of adhesions and perhaps their location relative to implantation that seems important. There are no statistics available on conservative management of this condition, therefore it is not possible to predict clinical outcome. There is no indication for treatment in pregnancy.

Hysteroscopic complications of surgery include bleeding, perforation of the uterus and pelvic infection, although these are uncommon. In some cases, treatment of Asherman's syndrome will not cure infertility. For menopausal symptomatic women [4] when it is technically impossible to exclude endometrial malignancy, total abdominal hysterectomy may be indicated.

References

1. March CM (1995) Intrauterine adhesions. *Obstet Gynecol Clin North Am* 22:491–505
2. Badawy SZ, Orbuch L, Khurana KK (1998) Secondary amenorrhea with severe intrauterine adhesions and chronic uterine torsion after Cesarean section in a teenage girl. *J Pediatr Adolesc Gynecol* 11:93–96
3. Salle B, Gaucherand P, de Saint Hilaire P, Rudigoz RC (1999) Transvaginal sonohysterographic evaluation of intrauterine adhesions. *J Clin Ultrasound* :131–134
4. Sandridge DA, Councill RB, Thorp JM (1994) Endometrial carcinoma arising within extensive intrauterine synechiae. *Eur J Obstet Gynecol Reprod Biol* 56:147–149
5. Pace S, Stentella P, Catania R, Palazzetti PL, Frega A (2003) Endoscopic treatment of intrauterine adhesions. *Clin Exp Obstet Gynecol* 30:26–28
6. Vasserman J, Baracat EC, Barbosa AJ, Haidar MA, Credidio RM, Fascina LP, De Lima GR (1987) Intrauterine adhesion: analysis of 28 cases *J Bras Ginecol* 97:419–422