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CASE REPORT

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# A case of Ashermann's syndrome following surgical evacuation of uterus for secondary postpartum haemorrhage

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**Abstract** Surgical evacuation of uterus for retained products of conception following delivery is a very common procedure but can have important sequelae. The possibility of causing Ashermann's syndrome, although rare, should always be borne in mind. If severe enough, it can render a woman essentially infertile, which can have serious psychological sequelae. Hysteroscopic recavitation is not only complex surgery, but it is also associated with potential problems even when successful, so realistic counselling is essential.

**Keywords** Ashermann's syndrome · Postpartum haemorrhage · Therapy

## Case report

A 32-year-old woman underwent a spontaneous vaginal delivery of her first child in March 1999. This was complicated by secondary postpartum haemorrhage. She underwent an evacuation of uterus with removal of placental tissue using suction curettage. Following this, she had an additional 500-ml haemorrhage. She did not need transfusion but was given prophylactic antibiotics for 7 days. She had an IUCD fitted at her 6-week postnatal examination by her general practitioner. Her menses never resumed and she was not breast feeding. She suffered from postnatal depression following delivery of her child, and it was initially thought that there was a psychological or hypothalamic cause for her amenorrhoea, although hormonal profiles proved normal. A hysteroscopy performed in June 2001 revealed an IUCD lying in the upper cervical canal with the endometrial cavity obliterated by dense adhesions and the tubal ostia could not be identified. A hysterosalpingogram performed post-operatively showed no evidence of dye passing beyond the cervix. She was then referred to Aberdeen Royal Infirmary and underwent hysteroscopic division of dense intrauterine cavity adhesions in January 2002. This was performed under laparoscopic control using Wolff 8.5-mm hysteroresectoscope with a 90° resection hook and glycine for irrigation. By the end of a difficult procedure performed with antibiotic cover, the cavity was reformed but there was no evidence of patent tubal ostia. A small (0.5 cm) perforation was made in the right anterior cornual wall seen under direct vision at laparoscope and there was no other damage. At the end of the procedure, an IUCD was placed in the cavity to prevent reformation of intracavity adhesions and the plan was for this to remain in situ for 3 months. She was put on oestrogen replacement therapy to try and encourage endometrial growth and also remained on antibiotics for 1 week. The IUCD had to be removed after 6 weeks because of pelvic discomfort and a fear of endometritis. She had three light periods lasting 1–2 days each month following the procedure. She underwent a repeat hysteroscopy and laparoscopy in May 2001. A 2.5-cm-long, narrow and fibrosed cervical canal opened into a left-sided tubular 4-cm cavity lined with active endometrium. The right side of the cavity had re-obliterated with dense adhesions. There was no evidence of a patent tubal ostium and there was no tubal fill or spill of dye at laparoscopy and hydrotubation.

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## Discussion

We report a case of severe Ashermann's syndrome. This is an extremely uncommon occurrence following postpartum haemorrhage for which vigorous surgical evacuation of the uterus is almost always implicated [1]. In this case, when the initial IUCD was inserted 6 weeks postpartum, it was felt that a false passage had been created. Concordant amenorrhoea raised the possibility of Ashermann's syndrome, which was confirmed at initial hysteroscopy and hysterosalpingogram [2, 3]. When this woman underwent subsequent hysteroscopy and division of endometrial adhesions, it was done with the objective of recreating a functional endometrial cavity which would be receptive to a further pregnancy, either spontaneous or through assisted conception [4, 5, 6]. Later hysteroscopy revealed a narrow and tubular endometrial cavity without identifiable tubal ostia which was also almost certainly unsuitable for embryo transfer.

A retrospective case study in France evaluated the efficacy of hysteroscopic adhesiolysis in patients with

severe Ashermann's syndrome [6]. They restored uterine cavity with one functional ostium. All previously amenorrhoeic patients had resumption of menses. A pregnancy rate of 42% was obtained with a live birth rate 32%. These pregnancies were at high risk of haemorrhage with abnormal placentation, premature labour, uterine sacculations and a paper-thin uterine fundus.

An Australian study found safe and effective hysteroscopic division of adhesions difficult, if not impossible, in patients with severe Ashermann's syndrome [6]. There is also a suggestion that in patients with intrauterine adhesions severe enough to produce amenorrhoea, biologically active endometrium can undergo malignant change [7].

An Egyptian study attempted to show the possibility of an association between Mullerian duct malformations and Ashermann's syndrome [8]; the association was highly significant ($p<0.005$), especially for those patients with a septate uterus ($p<0.001$). This predicament, though uncommon, brings to the forefront the importance of surgical evacuation of uterus for retained products following delivery.

The possibility of Ashermann's syndrome, although rare, should always to be borne in mind. If it is severe, as in the case illustrated, it can render a young woman essentially infertile, which will obviously have serious psychological squealae. Hysteroscopic recavitation is not only complex surgery, but it is also associated with potential problems even when successful, so realistic counselling is essential.

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