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SM Journal of Case Reports

Case Report

Atypical Case of Asherman Syndrome (Fritsch Syndrome) Due To Prolonged Retained Fragment of Cu-T in Myometrium

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Article Information

Received date: Jan 25, 2017
Accepted date: Feb 17, 2017
Published date: Feb 22, 2017

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Keywords Asherman syndrome; Intrauterine adhesions; Menstrual irregularities and infertility; Retained Cu-T fragment; X-ray abdomen diagnosis

Abstract

Asherman or Fritsch syndrome is also known as intrauterine adhesions. It can lead to partial or complete dysfunction of the endometrium. It affects women of all races and ages equally suggesting no underlying genetic predisposition for its development. The incidence is 40% after D and C. It is mostly due to vigorous curettage of endometrium causes scarring and occlusion in the uterine cavity or it may also be due to pelvic infections. Often patients experiences menstrual irregularities, recurrent abortions and infertility. A female married woman aged about 41 years came to Gynaecology OPD, National Institute of Unani Medicine (NIUM) hospital, Bangalore in 2015 with the complaints of menstrual irregularities and infertility. On the basis of signs, symptoms and imaging techniques such as USG, X-ray, Hysteroscopy and Laparoscopy the case was diagnosed as Asherman or Fritsch syndrome due to prolonged retained fragment of Cu-T in the myometrium.

Introduction

Asherman syndrome or Fritsch syndrome is a rare condition was first described by Fritsch in 1894 as intrauterine adhesions and then further studied by gynecologist Asherman in 1948 [1]. A study reported that about 40% of patients who underwent repeated D&C for retained products of conception after miscarriage or retained placenta developed Asherman syndrome [2]. Intrauterine adhesions can also form after endometrial tuberculosis or schistosomiasis infection. Intrauterine and cervical adhesions can lead to partial or complete dysfunction of the endometrium with menstrual abnormalities, when the adhesions are exclusively located in the cervix they lead to repeated miscarriages and impairment of fertility. This syndrome can also cause severe pelvic pain and endometriosis. However, such symptoms could be related to several conditions. They are more likely to indicate Asherman syndrome if they occur suddenly after a D&C or other uterine surgeries [3].

On physical examination patients with Asherman syndrome have normal height and weight. Conventional ultrasonography, hysteroscopy and laparoscopy can be used to evaluate this condition. Management of Asherman syndrome includes psychosocial counseling to address the functional abnormality, chances and success of pregnancy rate. Treatment includes Adhesiolysis by hysteroscopy [4]. Women who are infertile because of Asherman syndrome may be able to conceive after treatment. Success rate of pregnancy depends upon the severity of Asherman syndrome and the difficulty of the treatment [5].

Case Report

A married female patient aged about 41 years attended Gynaecology OPD of National Institute of Unani Medicine, Hospital during the year of 2015 with the complaints of menstrual irregularities since 15 years and she was anxious to conceive. She had previous reports of routine laboratory investigations. She was admitted and on interrogation she revealed that her married life was 22 years. She had a history of two months spontaneous abortion and evacuation was not done. She had a normal vaginal delivery 20 years back and Cu-T was inserted after delivery. Cu-T was removed after 5 years for conception in local health centre. After 2 years of Cu-T removal she developed menstrual irregularities with lower abdominal pain. The patient had also history of withdrawal bleeding on and off. There were no history of systemic illness, thyroid dysfunction and surgical intervention. Patient had mixed diet with good appetite, sleep and bowel habits were normal. On physical examination she was of average built, height was 152 cm and weight was 60 kgs and BMI was 25.9 kg/m^2. Pallor, cyanosis or puffiness was not seen on face. Breasts were normal. On systemic examination chest was bilaterally symmetrical, no added sounds were present. Heart sounds were normal. On abdominal examination abdomen was flat, no scar, tenderness or organomegaly was found. On genital examination, external and internal genitalia were normal.

Vitals were normal, blood pressure was 110/70 mm of Hg, pulse 82/min, afebrile and respiratory rate was 22/min. She consulted gynecologist for the complaints of menstrual irregularities and was investigated accordingly. Hormonal profile was not done. She had USG on 10/3/2015 showed fragment of Cu-T in myometrium of upper uterine segment. Uterus size was 7.0 cm, breadth 3.6 cm, transverse diameter was 4.0 cm and endometrial thickness was 7.0 mm. Right ovary measure about 2.6 X 1.9 cm and left ovary was 2.6 X 2.0 cm. POD was free and other findings were normal.

Other imaging techniques like diagnostic Hystero-laparoscopy was performed on 16/4/14 and it revealed uterine cavity length as 3.5", uterine cavity was reported irregular with multiple adhesions (firmly dense) and these feature were suggestive of Asherman syndrome. Fundus/bilateral ostial bicornua was not visualized properly due to adhesions. Endocervaical canal was seen normal. Laparoscopy findings on 16/7/14 suggested increased vascularity with sigmoid colon densely adherent on posterior wall covering pouch of Douglas. Right fallopian tube was reported adherent to sigmoid colon. Bilateral ovaries were not visualized due to bowel adhesions. X-ray of abdomen was done on 24/6/14 which showed densely echogenic foci on endometrium. Endometrial calcification and retained Cu-T fragment was seen. On the basis of signs and symptoms and radiological findings it was diagnosed as a case of Asherman syndrome due to prolonged retained Cu-T fragment in the myometrium of uterus.

Discussion

Asherman syndrome or Fritsch syndrome is a condition where the cavity of the uterus develops adhesions. The symptoms, extent of the adhesions, effect on the uterine cavity and clinical importance greatly influence the QoL of the patients. It can results from pelvic surgeries including dilatation and curettage in case of abortion or heavy bleeding, LSCS, myomectomy, genital tuberculosis, IUCD insertion, following post abortal and puerpeural curettage, diagnostic curettage in dysfunctional uterine bleeding and pelvic infections etc. Honey comb appearance on USG is the most important feature of Asherman syndrome. Hypomenorrhoea or ammenorrhoea is the main clinical feature. It is one of the causes of recurrent abortion and infertility due to formation of intrauterine fibrous adhesions and synaechiae [6,7]. Surgical treatment includes Adhesiolysis under hysteroscopic guidance, followed by IUCD insertion in mild to moderate cases. The success rate is high in mild and moderate cases, whereas severe cases like deep endometrial or myometrial trauma are uncorrectable [4].

If the uterine cavity is normal, but the ostia remain obliterated, IVF remains an option in case of infertility. Age is another factor contributing to fertility outcomes after treatment of Asherman syndrome. In women below 35 years of age pregnancy rates are 66.6% as compared to 23.5% in women older than 35 years. If the uterus severely damaged, surrogacy or adoption may be the only option. Patient who carries the pregnancy even after treatment may have an increased risk of abnormal placentation and abortion [7]. In this case the Cu-T was not removed properly and its fragment was left in the myometrium for long period which formed intrauterine adhesions. Therefore she developed menstrual irregularities and infertility. Age of the patient was also one of the factors for infertility. For this reason the patient was advised surrogacy for children.

Conclusion

The present case with long history of menstrual irregularity along with secondary infertility was evaluated thoroughly on the basis of clinical examination and relevant investigations; the patient was diagnosed as of Asherman syndrome because of Cu-T induced intrauterine adhesions. The most important step in this case was proper diagnosis and effective management of the underlying condition. Due to wide variation in clinical presentations, Asherman syndrome may be difficult to diagnose. Evaluation for associated abnormality and psychosocial counseling before any treatment or interventions are essential. Because of the implication for reproduction, these patients require psychological support, which should be offered as a part of therapy.

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