



Full length article

Feasibility and efficacy of repeated hysteroscopic cesarean niche resection



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ABSTRACT

Objective: Cesarean-induced niche can cause symptoms such as abnormal postmenstrual bleeding, pain and associated infertility. Hysteroscopic niche resection is usually a successful treatment, but can result in a failure to improve symptoms or symptoms can recur. In the present study we aim to evaluate the feasibility, effectiveness, and safety of a second hysteroscopic niche resection for patients in whom an initial hysteroscopic resection failed to improve symptoms.

Study design: This retrospective cohort study (Canadian Task Force classification II-2) hospital tel hashomer (tertiary center) included all patients who underwent a second hysteroscopic niche resection between 2011 and 2015. Measurements: Fertility, obstetric outcomes, clinical outcome and complications were compared between the first surgery and the second

Results: Eight patients underwent a second hysteroscopy after failure of the first hysteroscopy to resolve symptoms or after recurrence of symptoms. Abnormal uterine bleeding (AUB) was the most common symptom, occurring in all patients. The average number of days of bleeding per cycle were significantly reduced following the second surgery [14.50 (range 8–21 days) vs 11.75 (range 8–20 days), respectively $p = 0.009$]. The second surgery improved symptoms in 6 out of the 8 patients with AUB and 1 of 2 patients with pain. There were no significant differences in fertility and obstetric outcomes between the first and the second surgery and no complications were reported during any of the surgeries.

Conclusion: Reintervention with a second hysteroscopic niche resection is both feasible and effective treatment option following a failed first attempt or recurrence of symptoms. The second surgery improved symptoms, especially AUB, with no consequent detrimental effect on obstetric outcomes on our series.

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1 Introduction

Over the last few decades, the rate of cesarean section and the number of women undergoing multiple cesarean sections have nearly doubled [1], reaching as high as 32% in the united states. This was followed by increased complication rate [2] and the appearance of a new clinical pathology, the cesarean scar defect, known as isthmocele or niche [3]. This pathology is now one of main interest of clinical research in gynecological surgery.

Niche is a reservoir-like pouch defect on the anterior wall of the uterine isthmus, that is located at the site of a cesarean delivery

scar [3]. After cesarean section an anechoic area defining the niche at the site of the scar has been described in 24 to 69% of women evaluated by transvaginal sonography and this reached 57-to 78% of women evaluated by hysterosonography.

The first description of the bleeding in relation to the cesarean section scar defects date from 1975.

A common symptom reported to be associated with the presence of the niche is abnormal uterine bleeding (AUB) [4]. This pathology is characterized by spotting for a variable number of days after menstruation. Other reported symptoms associated with niche include pelvic pain, dyspareunia, urinary discomfort and possible secondary infertility [3–6].

The mechanisms responsible of AUB has been described has the retention of menstrual blood in niche which is intermittently expelled after menstruation have almost stopped, causing post-menstrual spotting and pain. The fibrotic tissue below the niche

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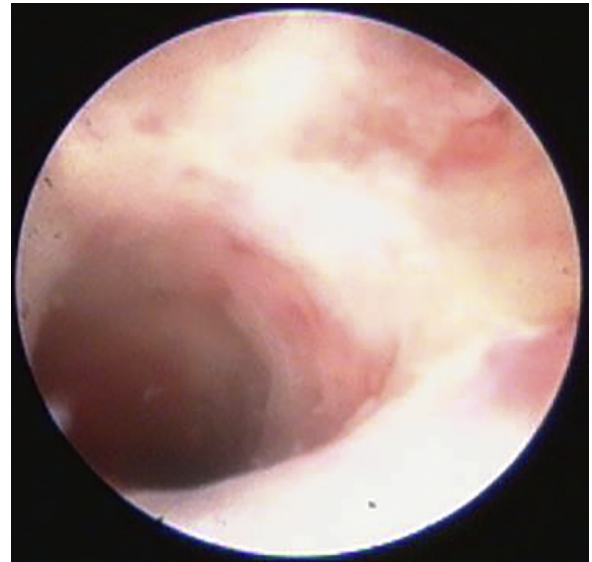
may impair the drainage of menstrual flow. The newly formed fragile vessels in the niche may also contribute to the accumulation of blood produced in situ.

The ultrasound or hysteroscopic presence of a niche after a cesarean has we said previously is very common (more than 50% of the women after cesarean section) however only 30% of them experience post menstrual spotting, 53% experienced dysmenorrhea, 36,9% chronic pelvic pain and only 18,3% dyspareunia. The diagnostic criteria of a the niche are still a subject of debate but treatments are offered today only for the symptomatic patients. Recent publications have described the efficacy of different treatments to cure the symptoms related to the niche [8–14], ranging from hormonal therapy to various surgical procedures (i.e. laparotomy, vaginal, hysteroscopic, laparoscopic and robotic-assisted surgeries).

Post cesarean section niche is becoming more commonly diagnosed and its reported incidence widely varies between 24 and 84% [5]. This increase in diagnosis is due to several factors, including the increased rate of cesarean sections, the rising awareness of obstetrics and gynecology practitioners, and the improvements in diagnostic tools [6]. The diagnosis is mainly determined by visualization of an anechoic area at the level of the scar using transvaginal ultrasound (TVUS) (Picture 1) [7], transvaginal sonohysterography [5], or diagnostic hysteroscopy (Picture 2).

Hysteroscopic resection of niche is the least invasive surgical procedure. The goals of the hysteroscopic procedure are to facilitate menstrual blood drainage and to reduce in situ production of blood by coagulating niche vessels [10]. The indications for surgery are AUB, or more specifically, postmenstrual bleeding, pelvic pain, and less commonly, infertility, sexual dysfunction or urinary symptoms. The reported success rate for improving symptoms after surgery is approximately 80% after hysteroscopic resection [10,15,16] and 100% after vaginal [14] and laparoscopic repair [9]. However, little is known about how to manage a previous failed hysteroscopic resection or a recurrence following a previous effective surgical treatment.

The aim of our study is to evaluate the feasibility, effectiveness and safety of a second hysteroscopic surgery in case of failure of the first hysteroscopy to improve symptoms or cases in which symptoms reoccurred.



Picture 2. Hysteroscopic view of an isthmocele.

2 Material and methods

A retrospective cohort study performed at the Sheba and Herzelya Medical Centers in Israel. The study was approved by ethical committee under the Helsinki approval number HMC-0011-16.

Inclusion criteria:

- failure of first hysteroscopy; defined by the persistence of postmenstrual bleeding and/or spotting for at least 3 months after the first procedure
- recurrence of niche; defined as reappearance of a niche, after at least 1 year following the first effective surgery, coincident with symptoms.

Exclusion criteria:

- Other associated pathologies that could cause AUB diagnosed by ultrasound or hysteroscopy:
- Endometrial polyp



Picture 1. Ultrasound of an isthmocele with measure of the wall of security.

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