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NEWSLETTER

I started 14 years ago in the wondrous world of hysteroscopy and I set a goal, as well as a challenge for myself, to make gynecologists understand that blind procedures on the uterine cavity carry a big risk and have various limitations, that only hysteroscopy surpasses.

Along with my professor, Dr. Alfonso Arias, we calculated in total around 170 physicians trained in the technique, of which, only 10% apply it on a daily basis.

Hysteroscopy is done in the private sector, and is nonexistent in the public one, which is where the vast majority of people receive care, and is also where the future specialists are taught and molded without this technique in their repertoire.

After years of studying, most specialists know the benefits and indications of hysteroscopy, which is why an increasing amount of patients are benefiting from this method. Nonetheless, many patients have already gone through blind procedures. Why? Due to professionals ego of wanting to solve cases with what they were taught, and the need for work.

The procedure takes place either in office or the OR. This is due to administrative and insurance coverage reasons, and not medically driven, which is baffling as much of the world executes it mainly to the office.

In the office, my goal is to erase patients' conditioning to always undergo pain during their visits. Almost none of them arrive relaxed and trusting that this will be a relatively painless procedure, and this distrust is augmented by low socio-economic status. The reason, which is my personal view, and it's an opinion that might not be generally shared, is that in my specialty there is a great deal of gynecologic violence towards the patient.

Despite all this, Gynecologic Endoscopy is moving forward in Dominican Republic. It has a heartening projection, more than laparoscopy, due to its easy application and a shorter learning curve. Two factors for this growth to continue are the installation of focus groups that facilitate the learning curve and bring down the costs for the equipment. Another element is the training of the upcoming generation of gynecologists that would become the driving force for the broad implementation of hysteroscopy in my country's health system.



I definitely agree with Linda Bradley when she says "My hysteroscope is my stethoscope".

Milcíades Albert F. Dominican Republic **INSIDE THIS ISSUE**



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Panoramic view of the narrow cavity Tubal ostium are not visualized

Based on the new classification for uterine anomalies of the European Society of Human Reproduction and Embryology and the European Society for Gynaecological Endoscopy (ESHRE/ESGE) published in 2013, T-shaped uterine malformation is a rare Müllerian anomaly incorporated in the new category of dysmorphic uterus (U1), that is characterized by abnormally shaped uterine cavity and normal uterine outline, excluding septa. T-shaped uterus (U1a) is characterized by thickened lateral walls with hypoplastic uterine cavity and a correlation 2/3 uterine corpus and 1/3 cervix. This malformation, in the previous American Fertility Society classification was included in the VII class, based on the strong relation to diethylstilbestrol (DES) in utero exposure.

Altered volume and shape of the uterine cavity is supposed having a role in defective endometrial receptivity, and uterine malformations are often reported with higher prevalence in infertile patients and in those with repeated miscarriages. About T-shaped uterus, different studies reported poor reproductive outcome when this malformation was untreated.

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...

If you need a helping hand, you can always find one at the ESGE

Few months for the next ESGE congress. What will the new congress show us?

ESGE congress is always a unique opportunity for the endoscopic community to present the new achievements in our field and to review the accumulated knowledge in hot topics of endoscopic practice. For that the Scientific Committee of the Thessaloniki Congress invited almost 150 distinguished and well-known speakers to share their experience with the participants. The field of Gynaecological endoscopy expanded tremendously over the years covering the investigation and treatment of almost all benign pathology related to female fertility thus contributing to the wish of the couples to achieve a pregnancy, the treatment of lesions related to symptoms affecting women's well-being thus contributing to the improvement of the quality of life, the staging and treatment of gynecological cancer with minimally invasive procedures as well as the treatment of pelvic floor diseases more effectively. The program of the congress is totally new avoiding repetitions. As the endoscopic surgeons have to know not only how to do an operation but also when to treat a patient, a lot of topics are focused on that question. ESGE is also working on recommendations and guidelines in our field. The Thessaloniki Congress will be the forum to present the new recommendations on the treatment of deep endometriosis that was developed in collaboration with ESHRE and World Endometriosis Society as well as the recommendations on laparoscopic hysterectomy that will be the basis for the evaluation of endoscopic surgeons to get their ESGE Diploma.

In the program, we continued the successful initiative, established in our previous Vienna Congress, selected abstracts to be presented in the main sessions of the Congress, thus giving the opportunity to new scientists and endoscopists to present their new ideas, research results and achievements to our audience. It was proved that this attracts the new generation, which is the future of our Society. This year we had for the first time 680 submitted abstracts including 9 PhD submissions of impressive quality indicating the increasing scientific quality of our Congress.

Apart from the scientific program, in Thessaloniki ESGE will launch its new official journal, Facts Views and Vision in Ob Gyn (FVVO) and the GESEA Diploma on Minimally Invasive Surgery. Our new journal, owned by ESGE, is a unique combination of science and art: the Belgian artist Koen Van Mechelen, who will be also our invited speaker in the opening ceremony of the congress, is the designer of the journal layout. It is in pubmed, offering visibility to our authors and although it is open access it is also available in printed version. ESGE members and ESGE Corporate Societies members could publish in FVVO for free. Importantly, increased number of participants compared to the years before.



Grigoris Grimbizis

ESGE President

Female Genital Tract Congenital Malformations

> lassification, Diagnosis ind Management

Grigoris E. Grimbizis Rudi Campo Basil C. Tarlatzis Stephan Gordts *Editors*

2 Springer

The diagnostic work-up of women with female genital malformations is reviewed in an evidence-based fashion and taking into account the availability of new non-invasive diagnostic methods. The treatment strategy and the therapeutic alternatives to restore health and reproductive problems associated with their presence are critically reviewed. International Society for Gynaecological Endoscopy selected also FVVO as its official journal. As it is already known ESGE is focusing in training and certification with its unique GESEA program. In Thessaloniki, apart from the GESEA training and certification sessions, for the first time ESGE will launch its GESEA Diploma which is actually the certified recognition of the surgical skills of the endoscopic surgeon giving the opportunity to endoscopists to prove their ability to safely and effectively perform an operation.

However, each year the ESGE Congress is unique opportunity for networking: to meet friends, to get familiar with local culture and to have fun. Thessaloniki is a unique environment for that. Do not miss the opportunity to participate to this party. It is really amazing that this year we already have an

The amount of hysteroscopic procedures is increasing worldwide. What ESGE is doing to promote hysteroscopy?

Endoscopy has two arms: laparoscopy and hysteroscopy. ESGE started to put an increasing interest in hysteroscopy and in Thessaloniki Congress the participants could realize that. We increased the number of sessions on hysteroscopy, we continue our successful collaboration with the Global Congress of Hysteroscopy having a common session and we design a pre-congress course on hysteroscopy. One Keynote Lecture is in the field of hysteroscopy, having as an invited speaker Prof Stefano Bettochi. In our GESEA training and certification program hysteroscopy has a discreet role with validated exercises, which is further expanded over the years. It is note worthy to mention that in ESGE Diploma there will be an evaluation of the hysteroscopic surgical skills of the applicant and this will also presented in Thessaloniki Congress.

Actually, the friendly and successful collaboration that we developed all these years with the Global Congress on Hysteroscopy indicates the interest of our Society on hysteroscopy and the efforts to promote more and more this evolutionary technique worldwide.

Do we have definitive classification with the new ESGE/ESHRE system of female genital anomalies?

The ESGE/ESHRE classification of female genital anomalies represents a revolution in their categorization overcoming restrictions of the previous systems. It offers the frame to successfully classify all types of previous unclassified anomalies being a real comprehensive system. It offers the unique opportunity to be used as a guide of treatment not only of the uterine anomalies but also of the complex and obstructive ones. It offers the chance to objectively categorize the different types of uterine abnormality using well-defined criteria in clearly described categories.

It seems over the years that the main frame is acceptable. As it is expected, the new ESGE/ESHRE classification opens new horizons in some topics, as an example in dysmorphic uterus, and a debate in some others like the septate one. It seems also that new hypotheses on the pathophysiology of septate uterus might contribute to a different understanding of the uterine anatomy.

Hence, it is obvious that in the fore coming years, we could expect supplementary work in some categories based on the experience gained meanwhile. In the ESGE Congress in Thessaloniki, for the first time, an open discussion will be organized on the classification of female genital anomalies: do not miss the opportunity to participate to this attractive event.

Has the debate about hysteroscopy and fertility finished or is just starting?

Despite the fact that in the previous years two multicenter studies were published on that issue trying to definitively answer to the question if hysteroscopy has a place in the investigation of infertile patients with normal ultrasound findings who will undergo IVF, to my opinion this actually opens the discussion about the real place of hysteroscopy. It seems to me oversimplification to put everything in the same basket ignoring the limits of ultrasound technology and underestimating the escaped pathology: putting everything in one basket is not the best way of approaching a question. And as infertility specialist supports in their practice



individualization is the best way of clinical management. Hysteroscopy is the only way of detailed estimation of the uterine cavity and, the cavity plays a pivotal role in the achievement and evolution of a pregnancy.

Has the hysteroscopy reached it's limits?

It is impossible to put an end in human inventiveness. New tools in hysteroscopic technology simplify existing practices: the current introduction of mini-resectoscope and shaver changes our treatment. The gained experience in the evaluation of uterine cavity changes the way of looking the uterus e.g. dysmorphic uterus and endometritis are new entries in our diagnostic panel based mainly in the evolution of hysteroscopic techniques.

Hysteroscopy seems to play a new role in the evaluation and treatment of early endometrial cancer offering new alternatives in the conservative management of this category of patients. And that are only examples of recent advances. The future is still open.

Do you have any advice for the young physician who is starting out in the world of gynecologic minimally invasive surgery?

The world of endoscopy is really amazing. The young physician should be enthusiastic and inventive. On the other hand, it is really important to get the right skills in a structured way of training. They have to never forget that they are dealing with patients and safety should be their first goal. Treatment of life threatening lesions and improvement of life quality are our targets. Joining the endoscopic community is crucial for young people giving them the opportunity to learn from the accumulated through the years experience and

enriching the community with their enthusiasm and their new ideas. The logo of the 28th ESGE Annual Congress, coming from the Hippocrates era, "Primum non nocere: maintain safety while pushing the boundaries" should be always their guide.

Case Report

Hysteroscopy Newsletter Vol 5 Issue 5

Gastric-type mucinous well differentiated adenocarcinoma (adenoma malignum)

Beatriz Díaz-Rabasa,1 Andrea Espiau-Romera,1 Paula Cebolla-Gil,1 Celia Del Agua,2 María Pilar Del Tiempo-Marqués,1 Isabel Negredo-Quintana1
1 Servicio de Ginecología. 2 Servicio de Anatomía patológica.
Hospital Universitario Miguel Servet, Zaragoza, España.

ABSTRACT

Well-differentiated mucinous adenocarcinoma of the gastric type, also called malignant adenoma or adenocarcinoma of minimal deviation, is a rare histological variant of cervical mucinous adenocarcinoma. Persistent vaginal discharge or bleeding and cervical cystic formations are common symptoms of these rare condition.

Well-differentiated mucinous adenocarcinoma of the gastric type is aggressive, despite its nonspecific clinical and histopathological aspect of benign features. The differential diagnosis must be thorough and be established with benign cervical lesions. The pathological diagnosis prior to definitive surgery is imperative to reduce the morbidity and mortality associated with multiple surgical interventions and delayed optimal treatment.

To date there is no treatment consensus; therefore, each case must be individualized.

INTRODUCTION

Well-differentiated mucinous adenocarcinoma of the gastric type, also called malignant adenoma or adenocarcinoma of minimal deviation, is a rare histological variant of cervical mucinous adenocarcinoma. Its prevalence is estimated in 1-3% of cervical adenocarcinomas and in 0.15-0.45% of all cervical tumors. (1,2). The average age at diagnosis range from 42-57 years. (3-5)

The origin of the malignant adenoma is uncertain, unrelated to the human papillomavirus (5,6) however, its association with Peutz-Jeghers syndrome (10%) and with other ovarian neoplasms such as mucinous and sexual cords neoplasms such as mucinous and sexual cords tumors has been described (1,6-9)

The most frequent clinical manifestations include: seromucinous vaginal discharge (69.4%), spotting and postcoital bleeding (50%). (2,6,10,11) Pelvic pain is less frequent but cervical hypertrophy appears in 74.9% of cases. (6,12)

The diagnosis of mucinous adenocarcinoma is difficult to establish due to its unspecific clinical characteristics and benign histopathological appearance, which makes the differential diagnosis from other benign neoplasms. (2,7,10,12-14)

Keywords:

Adenoma Malignum, cervical adenocarcinoma, Vaginal discharge

CASE REPORT

A 52-year-old woman with obstetrical history of four caesarean sections, presented to the office complaining of prolonged history of vaginal discharge and bleeding.

Cervical cytology was negative for malignancy with positive human papillomavirus (HPV). Ultrasound reported multiple cervical Naboth cysts and fluid inside the endometrialm cavity. The endometrial biopsy verified the presence of mucinous content, with fragments of endometrial epithelium, metaplasia and minimal fragments of inactive endometrium.

At hysteroscopy the endometrial cavity was visualized without alterations and the endocervical canal with a small benign polyp. The cytological reports of the vaginal discharge and histopathology of endocervical curettage ruled out a malignant lesion. MRI showed numerous Naboth cysts, smaller than 2 cm, without additional pathologic findings.

Due to the persistence of symptoms a total hysterectomy with bilateral salpingoophorectomy was performed. The pathological report was a well-differentiated mucinous adenocarcinoma gastric type (malignant adenoma, adenocarcinoma of minimal deviation), stage IB2 (FIGO), associated with lobular hyperplasia of endocervical glands (Figures 3, 4, 5 and 6), with free surgical margins.

Adjuvant treatment with external radiotherapy and brachytherapy was established.

DISCUSSION

Malignant adenoma of the cervix was first described by Gusserow in 1870. (15) In 1975, Silverberg and Hurt (22) coined the term "adenocarcinoma of minimal cervical deviation" due to its benign features.

Recently, in 2014, the World Health Organization described this neoplasm as mucinous endocervical adenocarcinoma of the gastric type.(16)

Cervical conization. (2,4,7,13,17,18) Li and coauthors (6) reported a 32% diagnostic rate through cervical cytology, and up to 50.7% when multiple biopsies and/or cervical conization was performed.



The neoplasia is constituted by atypical endocervical glands, with low cytological grade, mucinous secretion and, occasionally, stromal desmoplastic reaction. (2,10,13,14,19,20)

Regarding immunohistochemistry, it is negative for p16 which represents a fundamental characteristic, indicating the absence of a causal relationship with HPV infection and estrogen and progesterone receptors. (20,21)

The differential diagnosis is established with Nabothian cysts, tunnel cluster, endocervicosis, mesonefrican hyperplasia and endocervical lobular glandular hyperplasia (by its acronym LEGH: lobular endocervical glandular hyperplasia). (4,7,13,17,22)







The surgical treatment of choice consists of hysterectomy with bilateral salpingoophorectomy. Although there are no established treatment guidelines, most studies suggest performing radical surgery. (1,4,7,13,21) Due to the possibility of lymphatic dissemination, pelvic lymphadenectomy is recommended. (4,6,10,13,17,18)

Malignant adenoma is a neoplasm of aggressive clinical behavior. (4,7). The survival rate of patients with malignant adenoma is lower than that of women with conventional endocervix adenocarcinomas associated with HPV. (4,17,18)

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Hysteroscopy Conundrums Intrauterine adhesions

Adhesions originating in the myometrium are the most common and are usually formed by muscular covered by endometrial tissue

What do you use to prevent adhesions?



5mo ---

8mo ---

1y •••



Nadya Manrique Espinoza • 1st Médico

Hyaluronic gel or foley catheter. Hormonal therapy in particular cases and depending on the diagnosis



Jeff Livingston • 2nd Chief Executive Office at Macarthur Medical Center

Does anyone place a Progesterone IUD for adhesions prevention?



Georgi Stamenov • 1st Founder & Head of IVF Clinic @ Nadezhda Women's Health Hospital

My protocol is hyaluronic gel after operation and one week after, to avoid new firm adhesions. High doses estrogen only in case of deficiency. Second look office hysteroscopy after two cycles.



Georgi Stamenov • 1st Founder & Head of IVF Clinic @ Nadezhda Women's Health Hospital

And another comment, I just saw today a presentation about treating adhesions with balloon under ultrasound guidance. I don't think it's a first step, but we can use it for prevention a secondary ones.



Hsuan Su • 1st China Medical University 學士

1y •••

1v •••

Foley cath, high dose estrogen, second look every two weeks



Luis Alonso Pacheco Author

Unidad Endoscopia Centro Gutenberg Malaga - Team Coordinator Hyst...

1y …

I also use a Foley Catheter and Hormonal therapy. But I think that one of the most important points is to perform an early "second look" hysteroscopy. In case of new adhesions, they are usually filmy or thin in that early hysterocopy, and they can be easily removed.



Adewole Adebayo • 2nd

Obstetrician and Gynaecologist at Federal Medical Centre Lokoja

1y ---

1y •••

1y •••

I use Foley catheter balloon size 8, 10 or 12 depending on the uterine cavity volume/size. The balloon is inflated with 3 to 4ml of sterile water. Additional hormonal therapy for 1 to 3months depending on the degree of adhesion. I perform second look hysteroscopy for only moderate to severe IUA. (edited)



Ricardo Lasmar • 1st Professor Associado de Ginecologia da Faculdade de Medicina da Univ...

I use mainly scissor, hormoniotheraphy and revision with new hysteroscopy (edited)



Parul Kotdawala • 1st Endoscopy Surgeon at Department of Ob/Gyn, V. S. Hospital & N. H. L. ... I have stopped using electric current as far as possible in the uterine

cavity. Am giving estrogens systemically for 10-15 days.

Have been promoting second look hysteroscopy within 2-4 weeks. But in private practice patients are reluctant.

Hyaluronidase based gels are not available in India, but would love to know others' experiences on them.

Am not using any interposition material like balloon or IUCD.

Obstetricia y Ginecología. CEO de la Unidad de Histeroscopia Gynecoro.



Jacobo Bahachille • 1er

5 días ---

I use Foley Cat and oral strogen and then second look

Ver traducción

Original Article

Iysteroscopy Newsletter Vol 5 Issue 5

Outpatient Hysteroscopy for Retained Products of Conception: Comparing two techniques

Dr. Tanvir, Dr. Meeta, Dr. Akanshi Tanvir Hospital, Hyderabad, India

Abstract

Objective:To determine the feasibility, time taken, completeness of removal of the pathology and satisfaction among patients undergoing Outpatient Hysteroscopy (OH) for retained products of conception by two different techniques.

Method:A total of 54 women with symptomatic retained products of conception following abortion or pregnancy termination in any trimester who were haemodynamically stable were included in this study. 29 patients underwent out patient hysteroscopy with 2.9 mm bettocchi using mechanical instruments and 25 patients underwent out patient hysteroscopy with 5C Truclear hysteroscopic tissue removal system.

Keywords:

Outpatient hysteroscopy, patient satisfaction, retained products of conception **Conclusions :** Out patient hysteroscopy represents a simple, safe and effective approach for intrauterine evaluation and treatment. Additionally, recent advances in technique and instrumentation facilitate this approach and, we believe, should encourage its higher adoption by the gynaecology community as it is patient and clinician friendly.

INTRODUCTION

1 % of pregnancies are complicated by RPOC and may lead to immediate complications such as continuous bleeding, infection, and late complications including intrauterine adhesions (IUAs) and infertility¹.

Traditionally dilatation and curettage used to treat retained products also exposes the uterus to potential trauma, with immediate complications including uterine perforation. The late sequelae are intrauterine adhesions(19 %) after sharp D & C, infertility and abnormal placentation^{2,3}.

Hysteroscopy allows direct visualization and would

be the best treatment of choice for patients affected by RPOC 4 , when the symptoms are not acute and patient is hemodynamically stable. Yet, there is not enough evidence regarding the best time to perform the removal of RPOC.

OBJECTIVE

The main objective of this study was to determine the feasibility, time taken, completeness of removal of the pathology and satisfaction among patients undergoing Outpatient Hysteroscopy (OH) for retained products of conception by two different techniques.

MATERIALS AND METHODS

This prospective comparative study was conducted at a private hospital. Hospital ethics committee approval was obtained.A total of 54 women with symptomatic retained products of conception following abortion or pregnancy termination in any trimester who were haemodynamically stable were included in this study. They presented with either ongoing irregular bleeding or lower pain abdomen. RPOC was detected using transvaginal ultrasound with colour doppler. 29 patients underwent out patient hysteroscopy with 2.9 mm bettocchi using mechanical instruments and 25 patients underwent out patient hysteroscopy with 5C Truclear hysteroscopic tissue removal system.

The choice of operative procedure was made by the chief surgeon with the consent of the women before enrollment. OH women were divided into two groups - Group I : Hysteroscopy was performed using a 4 mm continuous flow office hysteroscope (Bettocchi Office Hysteroscope size 4, Karl Storz, Tuttlingen, Germany) with a 2.9 mm rod lens optical system. Mechanical instruments such as scissors and grasper were used. Group II : Hysteroscopy was performed using a TruclearTM 5C (17F) Tissue Removal System. Both methods were done without the use of premedication or anaesthesia before, during or after the procedure.

MEASUREMENTS

We determined the feasibility, time taken and completeness of removal of pathology in both groups. Pain perception and patient satisfaction was assessed using the 100 - mm visual analog scale and likert's scale of satisfaction at baseline.

RESULTS

The mean age was 28 in Group I and 30 in Group II. Truclear 5C Hysteroscopic Tissue Removal System was more feasible in outpatient than 2.9 mm Bettocchi Hysteroscope with complete removal of retained products of size > 2.5 cm. The largest size in Group II was 5 cm. In Group I, the maximal size removed was 2.5 cm. Time taken was also shorter in Group II. Women were 100 percent satisfied in both groups with a pain perception VAS score of < 5. Mean time taken in Group I was 21.95 minutes and in Group II 10.29 minutes.



Detailed view of Retained Products of conception

DISCUSSION

In this prospective study we present preliminary results of 54 women who underwent outpatient hysteroscopic removal of retained products of conception (RPOC) by two different techniques. The major limitation of our study is a small sample size in each group and lack of randomisation.

1 % of pregnancies are complicated by RPOC and may lead to immediate complications such as continuous bleeding, infection, and late complications including intrauterine adhesions (IUAs) and infertility¹. Traditionally dilatation and curettage used to treat retained products also exposes the uterus to potential trauma, with immediate complications including uterine perforation. The late sequelae are intrauterine adhesions(19%) after sharp D & C, infertility and abnormal placentation^{2,3}

Hysteroscopy allows direct visualization and would be the best treatment of choice for patients affected by RPOC 4 , when the symptoms are not acute and patient is hemodynamically stable. Yet, there is not enough evidence regarding the best time to perform the removal of RPOC.

Out patient hysteroscopy with vaginoscopic technique is painless and safe procedure. The small diameter of both hysteroscopes makes the women more compliant, which is an important factor for a successful outcome⁵. The other advantage of hysteroscopy is that only the area of RPOC is excised, without causing damage to normal endometrial tissue. Mechanical removal of RPOC and avoidance of electric current lower the intrauterine inflammation and lower the risk of adhesion formation. It has been hypothesised that continuous rushing of the uterus with sterile solution during the hysteroscopy may reduce the risk of local infection and inflammation 6,7 .

In the Truclear group, it was feasible to remove larger size of RPOC with the maximum size of 5 cm and time taken was 18 minutes to excise the lesion. In Bettochi group it was easier to excise RPOC of size not greater than 2.5 cm. Mean time taken in Group I was 21.95 minutes and in Group II was 10.29 minutes. The fluid deficit in all procedures was less than 2000 ml. Truclear was advantageous over Bettocchi, as it was faster requiring less time, cuts and aspirates tissue and blood clots with only single insertion. There is no learning curve for use of Truclear tissue removal system⁸.

In this study, patients undergoing office hysteroscopy with Truclear 5C (Group II) had minimal pain, though the VAS was < 5 in both groups. This is because of no touch vaginoscopy technique of insertion and on encounter of cervical stenosis, the Truclear incisor insert was used to morcellate and open the fibres of the internal os without much movement of the scope. The other explanation for the reduced pain is single insertion, and reduced time of the procedure. Pain reduction, during vaginoscopy, is mainly due to the first phase of the procedure being vaginal distension by means of liquid, which is not painful, whereas the introduction of even the smallest speculum is usually poorly tolerated⁵.

We used mechanical instruments in such has 5 Fr scissors and biopsy forceps to navigate through the cervix in Group I. Indeed, in a revision of 5000 ambulatory hysteroscopies, performed at a Teaching Hospital Base, the authors demonstrated that cervical stenosis represents one of the failed principle causes of hysteroscopies .According to them, no sensitive nerve terminals or blood vessels have been demonstrated on the white fibrous tissue. The fibrotic ring may be cut at two or three point by using sharp scissors (5 F or 7 F) or may be stretched by grasping forceps first inserted within it with the jaws closed and then gently opened⁹.

The procedure was well tolerated in both groups and complete removal of RPOC with normal restoration of uterine cavity was achieved in 100 % of cases. No complications were reported intraoperatively. Histological confirmation was achieved in 92.5 % of patients. In the remaining cases, no clear RPOC was reported.

TruClear[™] System



Moreover, throughout the years, several studies have demonstrated that outpatient hysteroscopy shows good correlation of findings compared with inpatient hysteroscopy; presenting distinct advantages such as reduced anaesthesiology risks, enhanced time conservation ,cost effective and patient preference. Currently, outpatient hysteroscopy represents the gold-standard for the evaluation of the uterine cavity¹⁰.

The most common concern for any gynaecologist is that a patient who need surgery will undergo two procedures if there is a lesion to be removed. However modern hysteroscopic technology has made it possible to diagnose and treat most intrauterine pathologies in a single outpatient setting. Obviously, high patient compliance during the procedure represents the key prerequisite not only to reach a correct diagnosis but also to possibly treat those pathological conditions found in the uterine cavity. From the clinician's perspective, we found it to be convenient with use of minimal infrastructure, less of medication and personnel without compromising on the quality.

CONCLUSIONS

Out patient hysteroscopy represents a simple, safe and effective approach for intrauterine evaluation and treatment. Additionally, recent advances in technique and instrumentation facilitate this approach and, we believe, should encourage its higher adoption by the gynaecology community as it is patient and clinician friendly.

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Case Report

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Endometrial osseous metaplasia

Ochoa, C. M.; Calabrese, G. M; Sáez Perrotta, M. K; Gil S. J.; Saavedra Sánchez, A. J; Viglierchio, V. T.; Rosas P.; Uzal M. Section of Benign Pelvic Pathology and Endoscopy, Gynecology Service, Italian Hospital of Buenos Aires, Argentina.

ABSTRACT

Endometrial osseous metaplasia is defined by the non-neoplastic presence of mature or immature bone in the endometrial cavity. It occurs in 0.03% of women, more frequent in reproductive age and associated with a history of pregnancy and secondary infertility. The etiology is unknown.

Observational descriptive study of patients with hysteroscopy performed at the Italian Hospital of Buenos Aires between January 1999 and December 2017. Patients diagnosed with bone metaplasia findings were included.

Keywords:

Osseous metaplasia, Endometrial bone, Hyperechoic areas Although it is typically a pathology of reproductive age, it is important to highlight that almost 50% of the patients in our series were in the postmenopausal stage. In our case series, most patients (31.81%) arrived at the diagnosis due to incidental finding on ultrasound; that is to say they were asymptomatic.

INTRODUCTION

Endometrial osseous metaplasia is defined by the non-neoplastic presence of mature or immature bone in the endometrial cavity. It occurs in 0.03% of women, more frequent in reproductive age and associated with a history of pregnancy and secondary infertility. The etiology is unknown.

Hysteroscopy is the gold standard for diagnosis and treatment and involves the removal of metaplastic fragment. Usually after removal of the metaplastic contents, patients become asymptomatic and recover fertility.

OBJECTIVES

To estimate the prevalence of bone metaplasia during hysteroscopic procedures. To describe the clinical, epidemiological and hysteroscopic characteristics of the patients with ossseaous metaplasia.

MATERIALS AND MÉTHODS

Observational descriptive study of patients with hysteroscopy performed at the Italian Hospital of Buenos Aires between January 1999 and December 2017. Patients diagnosed with bone metaplasia findings were included.

RESULTS

During the study period, 14,100 hysteroscopies were performed, 20 of them with findings of endometrial bone metaplasia (prevalence of 0.0014%). Two patients without hysteroscopic findings but with pathology consistent with osseous metaplasia were also included (n = 22). The average age was 44 years, and the median was 39. Twelve were premenopausal (54.55%) and 10 postmenopausal (45.45%).

The most frequent reason for consultation was incidental ultrasound finding of hyperechogenic



area (31.81%), followed by postmenopausal bleeding (27.27%) and infertility (18.18%). Less frequent were abnormal uterine bleeding in premenopausal patients (9.09%), post-curettage after incomplete abortion follow up (9.09%) and secondary amenorrhea (4.55%).

The median number of pregnancies and previous deliveries was 1. The median of abortions and previous births was 0 for both (minimum of 0 and maximum of 2)

Fourteen patients (63.64%) had hyperechoic areas on ultrasound, 3 had endometrial polyps (13.64%), and the rest normal or with ultrasound images of IUDs or intrauterine adhesions. Of the 20 patients with hysteroscopic findings, 14 had calcifications on ultrasound (70%). Pelvic ultrasound showed a sensitivity of 70%, a specificity of 100%, a positive predictive value of 100% and a negative predictive value of 25% for the diagnosis of endometrial bone metaplasia.

Due to the loss of follow-up of some patients, the resolution of symptoms could not be properly documented. Follow-up was lost in almost half of the patients. Eight patients presented symptomatic improvement and one did not. Of the three patients with infertility, none achieved subsequent pregnancy during the study period.

DISCUSSION

Endometrial bone metaplasia is a very rare pathology, but it should be taken into account especially in patients who complaint of infertility and abnormal uterine bleeding, with or without history of pregnancy, abortion or curettage. The etiology of this infrequent condition is unknown. The most accepted theory is that of endometrial stromal cell metaplasia in osteoblasts due to chronic inflammation, mostly due to retention of





products of conception. However, in our population the median number of previous abortions followed by blind curettage was 0. This may be due to underreporting in Argentina; where abortion is illegal since 1921 except in two specific situations (As modified by the law in 2012): when the life of the woman is in danger and when the pregnancy is the product of a "rape or attack" (article 86 subsections 1 and 2 of the Criminal Code).

Another situation to consider is the increase in expectant management and medical treatment in the management of abortion in the first trimester, avoiding surgical treatments such as evacuating uterine curettage and endouterine manual aspiration. With this decrease in surgical treatment, uterine damage and its consequent endometrial inflammation are avoided.

The work of Cayuela et al. published in 2009 studied the DNA of the calcified material extracted from the uterus and maternal DNA and all the markers produced the same length of alleles for blood and endometrial biopsy (including bones), .thus confirming the same genetic origin and concluding that the Endometrial ossification is derived from the woman, resulting in true bone metaplasia. Strengthening the theory of endometrial inflammation and not the retention of products of conception

Although it is typically a pathology of reproductive age, it is important to highlight that almost 50% of the patients in our series were in the postmenopausal stage. Faced with this, we have two options to consider: it is a delay in the diagnosis because it is an asymptomatic pathology in many cases or the appearance of bone metaplasia in postmenopause. In our case series, most patients (31.81%) arrived at the diagnosis due to incidental finding on ultrasound; that is to say they were asymptomatic.

Due to the loss of patient follow-up data, we couldn't evaluate the resolution of symptoms and subsequent pregnancies in our cohort. However, an improvement of symptoms is published after the treatment of metaplasia by hysteroscopic removal of bone fragments. Hysteroscopy Newsletter is an opened forum to all professionals who want to contribute with their knowledge and even share their doubts with a word-wide gynecological community



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