

Hysteroscopic Outcomes in Our Clinic: 5 Years Experience

Osman BALCI¹, Rengin KARATAYLI¹, Ali ACAR¹, Metin ÇAPAR¹

Konya, Turkey

OBJECTIVE: The documentation of outcomes of hysteroscopic procedures carried out at Selçuk University, Meram Medicine Faculty, Obstetrics and Gynecology Department in 2002–2006 years.

STUDY DESIGN: 248 patients that have undergone hysteroscopy were included into the study. Operative indications and results were detected retrospectively.

RESULTS: There were 94 primary infertile patients, in 17 of these polypectomy, in 8 patients diagnostic hysteroscopy together with laparoscopy, in 47 patients uterine septum resection and in 22 patients hysteroscopic synechiolysis for Asherman's syndrome were carried out. There were 118 secondary infertile patients who had hysteroscopy for diagnostic purposes together with laparoscopy in 15 patients, for septum resection in 40 patients who had uterine anomaly, for habitual miscarriages in 25 patients, for polypectomy in 18 patients, for synechiolysis in 20 Asherman's syndrome patients. There were 7 patients with dysfunctional uterine bleeding and hysteroscopic endometrial ablation was performed for these patients. In 9 patients hysteroscopy was done to take out ectopic intrauterine device. In 8 patients hysteroscopic polyp extirpation and in 12 patients hysteroscopic sub-mucosal myomectomy was performed. Among 248 hysteroscopic procedure, 8 cases were complicated with uterine rupture, there were no other major complications related to procedure, so our complication rate was 3.2%.

CONCLUSION: Hysteroscopic procedures can be carried out for several indications and do not have frequent severe complication risks. The mostly seen complication is uterine rupture. In our series we have detected only 8 uterine rupture (3.2%).

(*Gynecol Obstet Reprod Med*; 13:3 153-155)

Key Words: Hysteroscopy, Hysteroscopic outcomes

Introduction

Currently, hysteroscopy is accepted as the most effective method for evaluation of endometrial cavity.¹ Hysteroscopy is used for diagnostic and therapeutic purposes, besides in some circumstances it is also helpful for evaluation of present pathology and efficacy of treatment. Hysteroscopy has several benefits and is applicable in infertility and dysfunctional uterine bleeding for diagnosis and treatment, for detection and to take out dislocated intrauterine device, for evaluation of pre-malign and early stage endometrial lesions, besides can be used for fetoscopy, chorionic villus sampling and hysteroscopic tubal sterilization.² In this study we aimed to demonstrate indications of hysteroscopic operations carried out in our clinic and their results.

Material and Methods

A total number of 248 patients who have undergone hys-

Department of Obstetrics and Gynecology Meram Medical Faculty Selçuk University Konya, Turkey

*Address of Correspondence: Osman BALCI
Selçuk Üniversitesi Meram Tıp Fakültesi
Kadın Hastalıkları ve Doğum Anabilim
Dalı Akyokuş Konya, Turkey
drobalci@yahoo.com*

Submitted for Publication: 04.05.2007

Accepted for Publication: 01.10.2007

teroscopic operations at Selçuk University Faculty of Medicine, Gynecology and Obstetrics Clinic in between 2002-2006 were retrospectively detected from hospital records. Indications for hysteroscopy and complications related to procedures were recorded.

Results

248 patients were included in the study. Most of the patients were operated for infertility. 94 hysteroscopic operations were carried out for primary infertility, for diagnostic and therapeutic purposes, among these polypectomy was performed in 17 patients, in 8 patients diagnostic hysteroscopy assisted laparoscopy, in 47 patients uterine septum resection and in 22 patients hysteroscopic synechiolysis was performed for Asherman's syndrome. 118 secondary infertile patients were included into the study, among these patients 15 diagnostic hysteroscopy assisted laparoscopy, in 40 patients septum resection was performed for uterine anomaly, in 25 patients hysteroscopy was carried out for habitual abortion, in 18 patients for polypectomy and in 20 patients for synechiolysis due to Asherman's syndrome. Hysteroscopic ablation was performed in 7 dysfunctional uterine bleeding cases. In 9 patients, dislocated intrauterine device was taken out. In 8 patients hysteroscopic polypectomy, in 12 patients hysteroscopic sub-mucosal myomectomy were carried out (Table 1). The pathology results of polypectomy specimens were reported as correlated with polyp. Patients who have undergone hys-

teroscopic synechiolysis were administered estrogen+cyclic progesterone combined treatment for 3 months duration after operation and all patients were evaluated by hysterosalpingography (HSG). In only 3 patients secondary hysteroscopic synechiolysis was needed. 87 patients who have undergone uterine septum resection were evaluated for control HSG in average 6 weeks after operation and in 12 patients persistent septum was detected. Among all 248 operations, 8 uterine perforations occurred; no other major complication was detected, so our complication rate was 3.2%.

Table 1: Hysteroscopic procedures in our clinic

Primary infertile 94 (37.9%)	Uterine septum resection	47
	Hysteroscopic synechiolysis	22
	Hysteroscopic polypectomy	17
	Diagnostic hysteroscopy	8
Secondary infertile 118 (47.6%)	Uterine septum resection	40
	Habitual abortion	25
	Hysteroscopic synechiolysis	20
	Hysteroscopic polypectomy	18
	Diagnostic hysteroscopy	15
Others 36 (14.5%)	Hysteroscopic myomectomy	12
	Ectopic intrauterine device	9
	Hysteroscopic polypectomy	8
	Endometrial ablation	7
Total 248 (100%)	Total 248 (100%)	

Discussion

The diagnostic efficacy of HSG as a screening test in infertility is appreciated by hysteroscopy. By this method, in 20% of patients with normal HSG, intrauterine pathology is detected.² In unexplained infertility, and In Vitro Fertilisation (IVF) cases some structural differentiations that progress asymptotically such as chronic endometritis, osseous metaplasia, endometrial vascular dystrophy, and glandular atrophy can be detected and appropriate treatment modalities can be planned.³

In modern obstetrics and gynecology, direct hysteroscopic biopsy is offered instead of blunt dilatation and curettage, and it should always be kept in mind that biopsy taken under direct visualization has more advantages.⁴ In our clinic, we take hysteroscopic biopsies in selected cases.

The most appropriate method to take out dislocated intrauterine device within endometrial cavity is again the method that is carried out under hysteroscopic visualization. In our clinic, first of all we try to take out dislocated intrauterine device bluntly, under local anesthesia, in cases we fail, we try hysteroscopic procedures.

Hysteroscopic myomectomy is usually performed for management of hemorrhage and for reproductive purposes. This procedure has some advantages such as, prevention from sur-

gery and short hospital stay at postoperative period. The postoperative conception rate in infertile women is 50% after myomectomy. The reported treatment rate after hysteroscopic myomectomy is 84%.⁵ We have detected clinical remission in all patients who had hysteroscopic myomectomy operation.

Hysteroscopy is an elite procedure in detection of localization of polyps and treatment of these pathologies. Endometrial polyps are of intracavitary pathologies and they usually result in abnormal uterine bleeding, infertility or both. In diagnosis, HSG, transvaginal ultrasonography, saline infusion sonography and Magnetic Resonance Imaging (MRI) are reported to be helpful, but the most important point they all fail is manipulation during diagnostic procedure.⁶ In our clinic for diagnosis of endometrial polyps, we use both HSG and saline hysterosonography. In all of our patients that had hysteroscopic polypectomy procedure, we detected clinical remission and all pathology results were concordant with polyps.

Asherman's syndrome is the first treatment indication that operative hysteroscopy had took place. Normal anatomy is restored by hysteroscopic synechiolysis, new adhesions are prevented by placement of intrauterine device, and resected tissues are regenerated by administration of estrogen. In some sources, in hysteroscopic synechiolysis cases, 75% conception rate and lower pregnancy losses are reported.^{7,8} In our clinic, at postoperative period after hysteroscopic synechiolysis, all patients were inserted intrauterine device, and all were administered estrogen+cyclic progesterone combined treatment for 3 months duration, and patients were evaluated by control HSG 3 months after operation. In only 3 patients, secondary hysteroscopic synechiolysis was needed.

Hysteroscopic operation is still important in uterine septum resection. Clinically, septate uterus decreases uterine capacity and vascularity and as a result leads to first and second trimester pregnancy losses. There is abortion or preterm labor risk varying between 15-95%.⁹ Following hysteroscopic surgery, anatomic restoration can be controlled by HSG. In our clinic, we apply HSG in an average 4-6 weeks after operation and in this study we performed secondary septum resection operation for patients in whom we have detected persistent septum.

Conclusion

Hysteroscopic procedures can be carried out for several indications and do not have frequent severe complication risks. The mostly seen complication is uterine rupture. In our series we have detected only 8 uterine rupture (3.2%).

References

1. Pantaleoni D: On endoscopic examination of the cavity of

- the woman. *Med Press Circ* 26:8, 1869.
2. Jinekolojik ve Obstetrikal Cerrahi. Cerrahi Histeroskopi. Güner H. Güneş Kitabevi, 2005:1139-57.
 3. Buttram VC, Reiter RC. Uterine and cervical pathology. Surgical treatment of the infertile female. 1985:249-287.
 4. Baggish S, Barbot J, Valle RF: Diagnostic and operative hysteroscopy. A text and atlas. Chicago: year book, 1988.
 5. Donnez J, Gillerot S, Bourgenjon D, Nisolle M. Neodmium YAG laser hysteroscopy in submucous fibroids. *Laser Operative Laparoscopy and Hysteroscopy*, 1989.
 6. Donnez J, Nisolle M. Laser hysteroscopy in uterine bleeding. Endometrial ablation and polypectomy. *Laser operative Laparoscopy and Hysteroscopy*, 277, 1989.
 7. Donnez J, Gillerot S, Bourgenjon D, Nisolle M. Neodmium YAG laser for hysteroscopic intrauterine adhesiolysis. *Laser operative Laparoscopy and Hysteroscopy*, 1990.
 8. Finikiotis G. Hysteroscopic adhesiolysis. *Aust NZJ Obstet Gynaecol* 1990;30:234-5.
 9. Homer HA, Li TC, Cooke ID. The septate uterus: a review of management and reproductive outcome. *Fertil Steril* 2000;73:1-14.