INTRODUCTION
This is a case report of a severe case of Asherman’s Syndrome who underwent multiple hysteroscopic procedures and embryo transfers over a span of 10 years. Her last embryo transfer was successful after the 5th hysteroscopy and high dose estrogen treatment. She delivered preterm twin babies.

CASE REPORT
Mrs. A was first seen with infertility and secondary amenorrhea. She was nulliparous with history of two surgical evacuations.

Her pelvic scan showed very thin endometrium of 2.5mm. She had hysteroscopy done 3 times to manage intrauterine adhesions in other centers.

When she then attended to start IVF treatment at St. Mary’s her FSH/LH level was very high and she was diagnosed premature ovarian failure. She underwent In Vitro Fertilization (IVF) cycle with donor eggs and partner’s sperm, had hormone replacement therapy (HRT) & fresh embryo transfer with single blastocyst but this was unsuccessful. Three blastocysts were frozen in that cycle.

First frozen embryo transfer with single embryo was unsuccessful. Prior to next embryo transfer scan showed fluid in endometrium. Diagnostic hysteroscopy diagnosed recurrence of Asherman’s Syndrome. Following this yet another operative hysteroscopy at our centre was done using versa point mainly and cold knife dissection towards the corneal ends. Hyalo-barrier gel was instilled, and copper coil was inserted, high dose estrogen was given for 6 weeks post operatively. Coil was removed after 3 months. She then had frozen embryo transfer with two blastocysts.

This transfer was successful and confirmed twin gestation. However, she had preterm prelabour ruptured membranes at 28 weeks gestation and delivered by Caesarean Section at 29+4 weeks. The birthweights of the babies were normal centiles for that gestation and were discharged home in good condition.

DISCUSSION
• Treating patients with Asherman’s syndrome and thin endometrium is an ongoing challenge in the field of Reproductive Medicine.

• Although the syndrome has been widely investigated, evidence of both
prevention of the syndrome and the ideal treatment are missing.

• Surgical management offers favorable fertility outcomes and is often successful in restoring menstruation. Surgical management with hysteroscopic lysis of adhesions is the gold standard for treatment and adopting an office-based approach offers several advantages.

• Prevention of reformation of adhesions remains challenging and no single method for preventing recurrence has shown superiority.

• Cell-based therapies using endometrial stem/progenitor cells hold promise for future use in regenerating inadequate endometrium.

• The recurrence rate following treatment is as high as 33%-66% depending on severity.

CONCLUSION

Increased awareness of the symptoms suggestive of intrauterine adhesive disease, as well as recognition of common causes and preceding events, is crucial for early diagnosis, patient counselling and treatment.

Type of adhesiolysis (versa point vs cold-knife), with judicious use of hyalo-barrier, coil & oestrogen led to success in this challenging case.

References

