بسم الله الرحمن الرحيم

SURGICAL APPROACHS FOR SYMPTOMATIC ISTHMOCELE

دکترمریم اشرفی
فلوشیپ لاپاراسکوپی،هیستروسکوپی
بیمارستان جامع بانوان ارش
پاییز ۱۴۰۰

- **A systematic review and meta-analysis**
- *Archives of Gynecology and Obstetrics* **(2020)**

33 PUBLICATIONS WERE RETRIEVED :
28 FOCUSED ON A SINGLE SURGICAL TECHNIQUE,
FIVE COMPARING DIFFERENT TECHNIQUES.

META-ANALYSIS SHOWED AN IMPROVEMENT OF SYMPTOMS IN 85.00% (75.05–92.76%) OF WOMEN AFTER HYSTEROSCOPIC CORRECTION,
92.77% (85.53–97.64%) AFTER LAPAROSCOPIC/ROBOTIC CORRECTION,
82.52% (67.53–93.57%) AFTER VAGINAL CORRECTION

Presentation

ASYMPTOMATIC : (2/3)
symptoms more common if residual myometrial thickness (rmt) <50% of adjacent myometrium

AUB: 30-80% with niche may have AUB
- often postmentrual spotting or IMB

secreting blood / mucous from niche which is hypervascular or has endometriosis within the scar

pelvic pain / dysmenorrhea: 34-68% of patients with niche have pain

INFERTILITY :10% reduction in fertility after c/s

DIAGNOSIS

ULTRASONOGRAPHY

24-70% post CS

- ideally performed on follicular phase cycle D7-14

essential measurements especially for the planning or surgery:

sagittal:

§ height

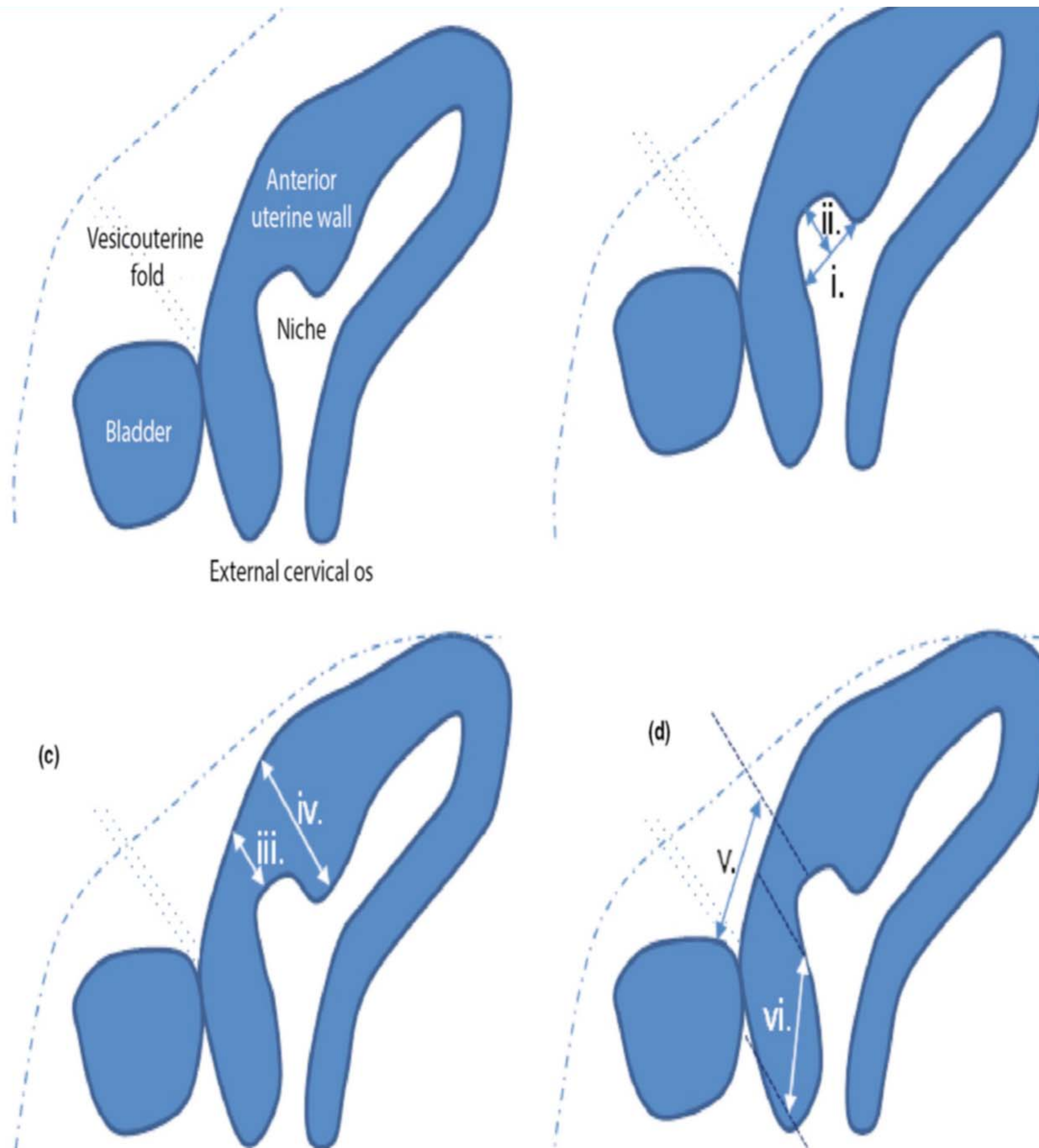
§ depth

§ distance from external os

§ bladder fold (vesicovaginal fold) to apex niche

§ RM and adjacent myometrial thickness (AMT)

transverse


Anterior
uterine wall
Vesicouterine
fold
Niche
Bladder
External cervical os
ii.
i.
(c)
iv.
iii.
(d)
v.
vi.

SSG

- 56-84% post CS
- more sensitive and specific than TVUS
- planning for surgical treatment
- potentially niche may appear bigger due to fluid distension

MRI

good correlation MRI and US to histology

Management
Depends on:
Symptoms
o Bleeding
o Pain
o infertility
Size
Future pregnancy

Surgical Approaches

HYSTROSCOPY

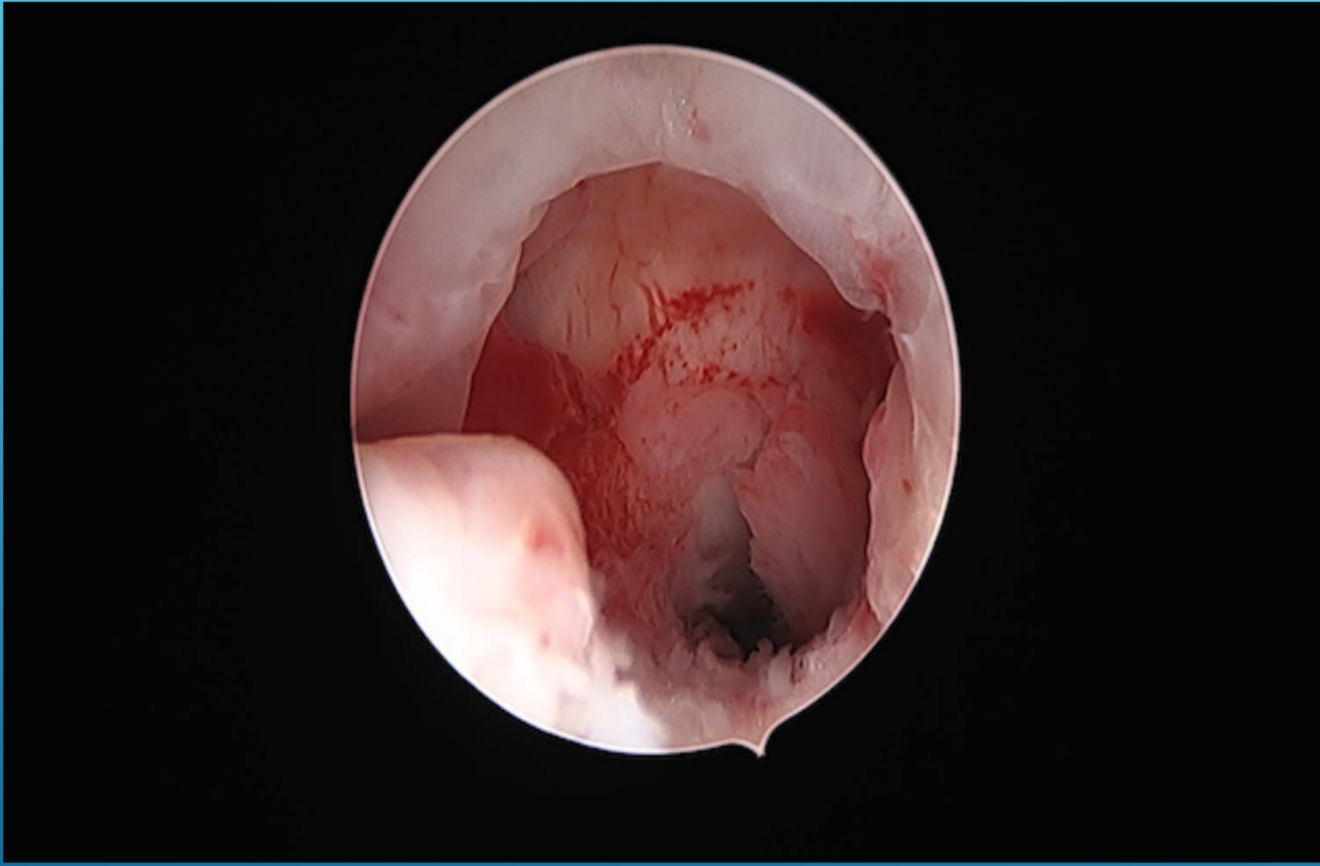
Some studies suggest RM >3mm with D/RMT ratio <50%

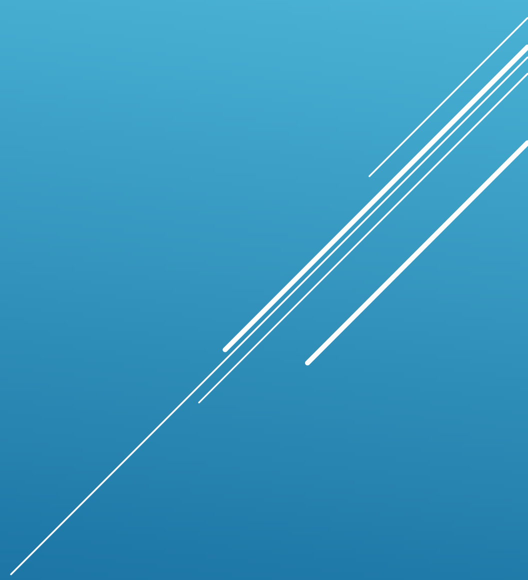
A cavity like defect seen in upper cervix
– vessels branching or punctuation

Thechnic:

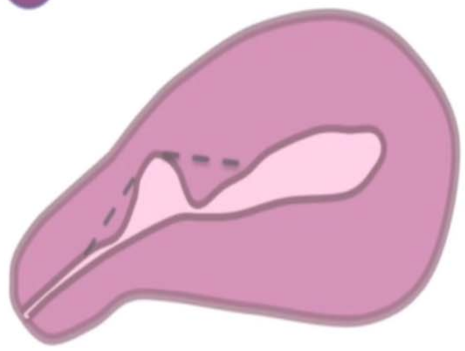
- Instillation blue dye in the bladder assists ID perforation
- Resect lower edge (distal)
- Resect upper edge (proximal) omitted in some studies concern about weakening of weakening cervix and cervical IC
- Ablate base

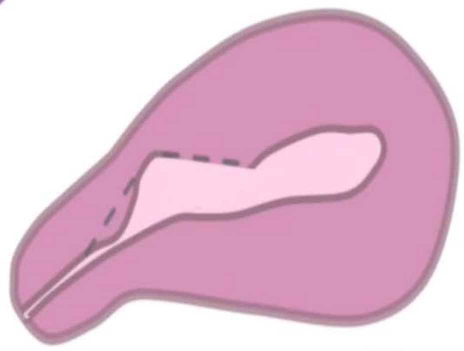
Risks: Bladder or utrine perforation

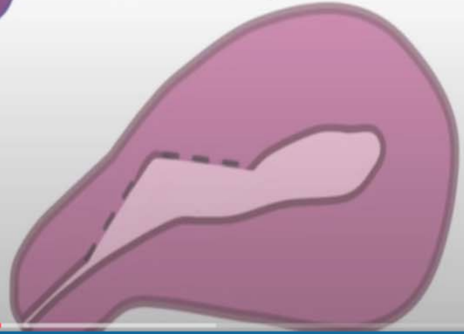


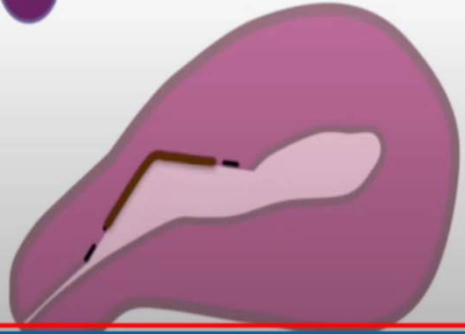


Review Steps of the Procedure









Laparoscopic repair

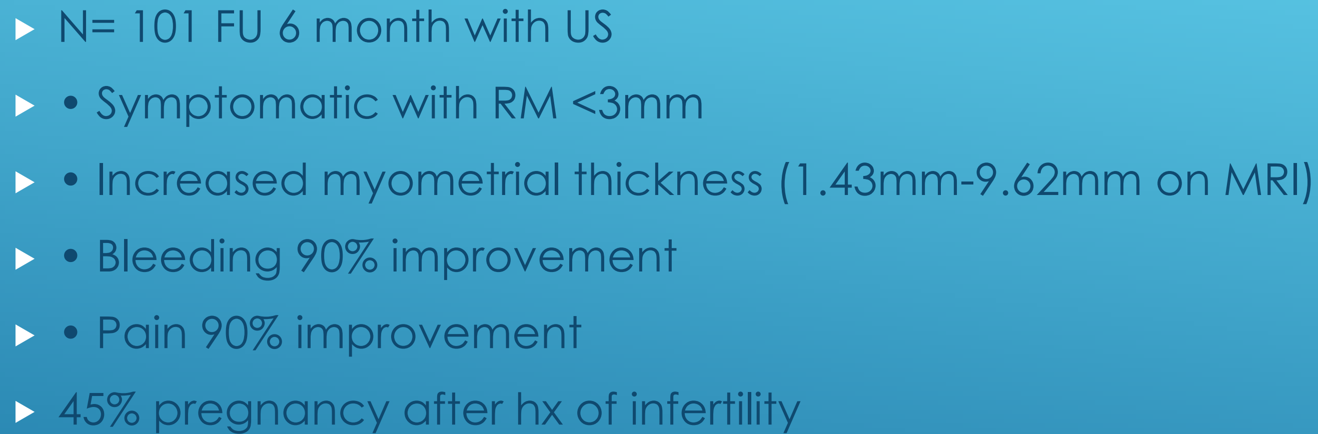
Criteria:

- • RMT<3mm
- • Wants to preserve fertility
- **Technique**
- • Combined laparoscopic / hysteroscopic surgery
- • ID the niche from below (typically hysteroscope which can transilluminate the

defect and delineate the borders of the niche

- • Dissect the bladder off lower segment
- • Excise scar tissue
- • Hysteroscope / Dilator in the cervical canal
- • Repair in1 or 2 layers – peritoneum ((0) or 2(0) vicryl / PDS with (0) V lock)
- Shorten round ligaments (esp retroverted uterus)

Vervoort 2018



- **Vaginal**
- Similar improvement of symptoms. about 86% in AUB
- More cost effective vs laparoscopy
- More blood loss than hysteroscopic approach
- Maybe challenging IDed scar defect vaginally with transillumination
- Unable to visualise other pathology
- Needs experienced vaginal surgeon
- Steps
- • Vaginal

Steps

- • Vaginal incision
- • Dissect bladder off the cervix/ lower segment
- • Incise bladder peritoneum
- • ID niche and excision (aided palpation + hysteroscope)
- • Repair in 2 layers

Hysterectomy

- Ultimatel treatment in those not desiring pregnancy.

Thank you!