

Laparoscopic isthmocele treatment – single center experience

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Abstract

Introduction: A cesarean section is the most frequently performed surgery in modern obstetrics. In case of an incorrect wound healing process there is a risk of a persistent uterine wall defect. Nowadays, due to the high frequency of cesarean sections, obstetricians have to deal with the threat of uterine rupture due to pathological wound healing. It has been proven that isthmocele can cause abnormal uterine bleeding (AUB), pelvic pain (PP), and secondary infertility (SI), and can be a place of improper pregnancy placement.

Aim: This article presents our experience with isthmocele treatment. We describe our diagnostic process scheme, method of corrective surgery and main therapeutic outcomes.

Material and methods: In this manuscript we present a single center's experience in isthmocele therapy. We have operated on 16 patients who suffered from abnormal uterine bleeding, pain disorders or secondary infertility possibly due to a cesarean scar defect.

Results: The results obtained in our center are promising. In 9 of 11 (81.8%) women with abnormal bleeding we obtained complete resolution of symptoms. We had slightly worse results in the case of pelvic pain. In 4 (66.6%) of 6 patients the pain resolved completely. We have obtained 7 pregnancies in 11 (63.6%) patients operated on due to secondary infertility.

Conclusions: In our opinion, laparoscopic treatment seems to be currently one of the most effective methods in isthmocele therapy. Further investigation is necessary to determine the indications for surgery, suitable treatment strategies and appropriate care.

Key words: isthmocele, cesarean scar defect, cesarean section, laparoscopy.

Introduction

A cesarean section is the most frequently performed surgery in modern obstetrics. For a few decades we have observed a permanent increase in the number of pregnancies ending with this method [1, 2]. The rate of cesarean section reaches up to 50% of all labors in many countries. In the United States of America, the rate of cesarean section increased from 23% to more than 30% between 1989 and 2005 [3].

In case of an incorrect wound healing process, there is a risk of a persistent uterine wall defect.

There are many terms used to name this pathology: isthmocele, niche, cesarean scar defect (CSD), cesarean scar pouch and others [4, 5]. In this paper we will mainly use the term isthmocele, as we use it in our daily clinical practice.

Nowadays, due to so many cesarean sections, obstetricians have to deal with the threat of uterine rupture due to pathological wound healing. Peripartum uterine rupture is a severe obstetric complication that can occur after a history of surgical intervention performed on the uterus (cesarean sections,

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myomectomy and other hysterotomy methods) [6]. The risk of uterine rupture is estimated to be 0.5% to almost 17%, depending on labor induction methods and other gynecological procedures [7, 8].

Scar defect can be the reason for other gynecological complaints. Isthmocele can cause abnormal uterine bleeding (AUB), pelvic pain (PP), and secondary infertility (SI), and can be a place of improper pregnancy placement (scar pregnancy) [9–12]. Patients who have a cesarean section have a 9% lower subsequent pregnancy rate than those who deliver vaginally [13]. Secondary infertility is proven to be higher in patients after cesarean section [4, 14]. Isthmocele can be a risk factor for morbidly adherent placenta and related complications [15, 16].

The literature describes prolonged birth (over 10 h), advanced cervix dilatation, oxytocin-induced contractions and retroverted uterus as the main risk factors for improper hysterotomy wound healing [17–20]. A value of 2.5 mm to 3.5 mm myometrium thickness is considered as critical in terms of impending uterine rupture in the pregnant uterus [8, 21].

The isthmocele diagnostic process includes medical history, gynecological examination, ultrasonography, and 3D ultrasonography. More complicated cases may require magnetic resonance imaging (MRI) [22–26]. In some centers sonohysterography is widely used [27–29].

There are mainly two surgical methods used in isthmocele treatment: hysteroscopic technique and transabdominal technique (via laparotomy or laparoscopy; depending on operator skills and experience). There are excellent reviews about all treatment methods, but there is still a lack of universal guidelines how to proceed with patients suffering from isthmocele [30]. There are no universal clinical guidelines to indicate which techniques should be preferred, or which of them gave better results in abnormal uterine bleeding, pelvic pain or secondary infertility treatment [4, 30–33]. Almost every center uses its own indications and methods, but this does not affect overall improvement of therapy. There is an interesting attempt to determine the scheme of isthmocele dependent infertility treatment, created recently by Tanimura *et al.* [34], but this is still a one-center guideline.

Aim

This article presents our experience with isthmocele treatment. We describe our diagnostic process scheme, method of corrective surgery, and main therapeutic outcomes.

Material and methods

In this manuscript we present a single center's experience of isthmocele therapy. Between January 2014 and January 2016 our center admitted 16 patients who suffered from abnormal uterine bleeding, pain disorders or secondary infertility, possibly due to a cesarean scar defect. All of them presented a history of at least one prior cesarean section.

We implemented a special diagnostic and therapeutic algorithm in all cases. Patients filled out the questionnaire with an emphasis on gynecological and obstetric history. Each patient was examined by palpation and after that referred for a detailed transvaginal ultrasound scan. The role of the scan was to determine the exact location and size of the isthmocele. The scanning was focused on visualization of the defect and measurement of remaining uterine muscle thickness. Isthmocele was defined as a hypoechoic region in the lower segment of the anterior uterine wall. Secondary infertility was defined as the inability to become pregnant after giving birth to one or more children in a 2-year period [35]. There are reports that count secondary infertility as a longer period, but they were not implemented in this study [36]. Abnormal uterine bleeding was defined as spotting, renewed bleeding after normal menstruation and excessive bleeding (menorrhagia). Pain during intermenstrual bleeding, dysmenorrhea and dyspareunia were defined as pelvic pain symptoms. Patients with additional gynecological ailments (fibroids, cancers, endometriosis, fallopian tube or ovarian pathologies) were excluded from the study.

Surgical protocol

After obtaining informed consent, each patient was offered a surgical, laparoscopic isthmocele repair. In all cases the procedure started with the use of hysteroscopy to detect the exact scar defect location. After that, three laparoscopy trocars were inserted. Firstly, the 10 mm trocar was inserted through the umbilicus; it was used for the optic device. Two 5 mm operation trocars were placed on both sides in the inguinal region. At the beginning of the procedure the peritoneum, uterus and adnexa were explored to search for additional pathologies. In case of adhesions disturbing the surgical field, blunt and sharp dissections were used. The tip of the hysteroscope was inserted into the defect – to indicate it. In some cases the defect could be recognized just by the optic light

transillumination through the thin scar cover. Whenever the location was not certain, a thin Hegar dilator was placed within the cervical canal to show the exact location of the isthmocele. The probe was pushed anteriorly to show the margins of the defect and eventually to puncture the top of the isthmocele defect.

In every case the lower uterine segment was composed of fibrotic tissue covered with peritoneum. The visceral peritoneum covering the defect was incised by scissors just after bipolar desiccation. The fibrotic tissue forming the borders of the defect was excised using both monopolar laparoscopic cautery and scissors to access the healthy vascularized myometrium. Complete resection of the fibrotic tissue was mandatory to facilitate further proper healing. After the surgical removal of the pathological tissues, a Hegar dilator was inserted to the cervix to preserve the continuity of the canal and uterine cavity during the suturing. The suturing was performed by two layers of the separate sutures. Every layer was covered with about 3 to 4 polyglactin 910 2/0 sutures (Vicryl 2/0 with SH needle). Great attention was paid to ensure correct myometrial wound margins adaptation and subtle hemostasis. Poliglecaprone 25 suture (Monocryl 4/0) was used in peritoneal covering. In all cases a control hysteroscopy was performed to visualize the repair and to prove the continuity of the cervical canal and uterine cavity. Each procedure took about 75–110 min, depending mainly on patient (BMI, adhesions) and operator factors (skills, experience). There were no associated complications in any of the presented cases.

Follow-up

The first postoperative ultrasound scan was performed during the next day after surgery, the second scan a month after. All patients were under strict observation for at least 6 months after surgery. During that time the assessment of the scar healing process was provided. Every patient was recommended the use of oral contraceptives. None of the patients was lost to follow-up. Patients who renewed pregnancies were followed up in a pregnancy outpatient clinic and they gave birth in our center.

Results

From the group of 16 symptomatic patients, 10 of them previously underwent one cesarean section, 4 patients had 2 cesarean sections and 2 of them had 3 cesarean sections. An isthmocele was found in

all 16 included patients. Mean residual anterior uterine wall myometrium thickness was 2.32 ± 0.54 mm.

The patients suffered from 3 kinds of symptoms: abnormal uterine bleeding, pelvic pain and secondary infertility. In 9 of them the isthmocele was the reason for multiple complaints. Abnormal uterine bleeding was diagnosed in 11, pelvic pain in 6 and secondary infertility in 11 out of 16 patients. Three patients suffered from both abnormal uterine bleeding and pelvic pain. Three of 16 patients suffered from both abnormal uterine bleeding and secondary infertility. There was a group of 3 patients suffering from all of the mentioned symptoms.

Postoperative outcome

Both patients who preoperatively suffered from AUB only were free of symptoms after surgery. From the group of 3 women who suffered from AUB and pelvic pain, after the laparoscopy 3 were free of bleeding abnormalities. One of them was still suffering from pelvic pain, whereas the 2 other patients stopped complaining about those symptoms.

There were 5 patients who suffered only from secondary infertility; 2 of them became pregnant after the laparoscopy and gave birth in week 38 of pregnancy. One of them is currently pregnant, and one had a blighted ovum pregnancy.

From the group of patients with abnormal uterine bleeding and secondary infertility, 2 patients were operated on and do not have any symptoms of bleeding abnormalities at the moment. One patient gave birth in week 37 of gestation, while another one is currently pregnant.

There was also a group of 3 patients with all mentioned symptoms. One of them became pregnant after surgery and gave birth in week 38 of gestation. One of them is free of abnormal uterine bleeding and pelvic pain, but is still in observation due to infertility. Another patient is still suffering from all symptoms, including infertility. Patients who were still suffering from secondary infertility were referred to an infertility clinic for subsequent assisted reproduction treatment. Patients' data are available in Table I. Examples of ultrasound scans before and after surgical correction are available in Photos 1 and 2. Table II presents the main symptoms, duration and therapy outcome. Table III lists all pregnancies which occurred after surgery.

Discussion

The percentage of women who have undergone a cesarean section is rising rapidly. There are initiatives to reduce the cesarean section rates, as described recently by Wilson-Leedy *et al.*, but many of them are rather ineffective [37]. Because of that, the risk of severe obstetric complications, such as uterine rupture, subsequent hemorrhage or morbidly adherent placenta, is still very high, regardless of the present therapeutic achievements [11, 15, 38–40]. The exact reasons for scar defects after cesarean sections still remain unknown [41, 42].

In gynecology, the existent literature focuses mainly on AUB as the main isthmocele derived syndrome [9, 10, 42]. Other problems, e.g. abdominal pain or abnormal urination, are often overlooked. The subject of isthmocele associated infertility is a topic that is slowly gaining a broader spectrum of debaters, due to the increasing proportion of related patients [14, 34]. The isthmocele has incorrect pH, which changes the mucus quality and is toxic for sperm [4, 12, 34]. In addition, the blood remaining in the pouch may be the cause of abdominal pain [9, 30]. It is important to be aware of the possible scar defect complications in the “cesarean section era”. Because of this awareness, patients should be offered the appropriate treatment. Proper diagnosis is necessary for the implementation of further steps [19].

Many authors diagnose isthmocele using hysteroscopy. It might also be a treatment option (depending on the center) [5, 9, 14, 34, 41, 43–45]. In the ultrasound, the isthmocele appears as a hypoechoic triangular area in the previous hysterotomy place. The proper measurement of the defect can be performed at the top of it. In many centers the diagnosis of isthmocele and a uterine rupture

Table I. Patient’s age, BMI and number of cesarean sections

No.	Age [n]	BMI [kg/m ²]	No. of CS [n]
1	33	17.46	1
2	34	17.96	1
3	31	18.6	2
4	29	20.47	2
5	27	17.84	1
6	31	17.7	1
7	37	21.39	1
8	36	19.19	1
9	33	17.19	3
10	32	17.39	3
11	35	20.71	1
12	42	20.96	1
13	38	17.27	2
14	37	17.88	1
15	32	18.26	2
16	33	18.93	1
Average	33.75 ±3.7	18.7 ±1.43	

high risk group is achieved when the mean thickness at the thinnest site is about 2.5 mm to 3.5 mm [8, 21, 46]. There is a high correlation between intraoperative findings and ultrasound observed lesions [10, 46]. There is a lack of consensus about the best treatment choice. In our opinion, in postmenstrual bleeding disorders, when family planning is not yet concluded, surgical correction should generally

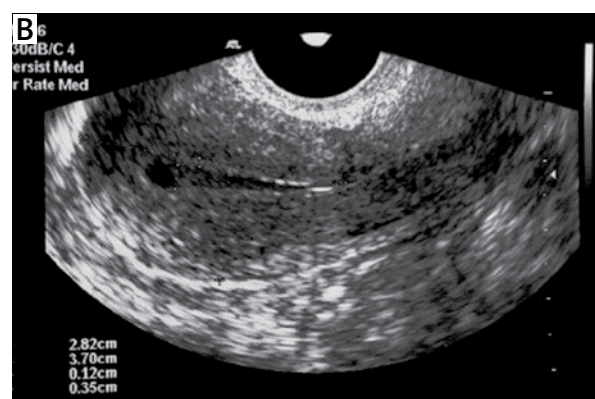
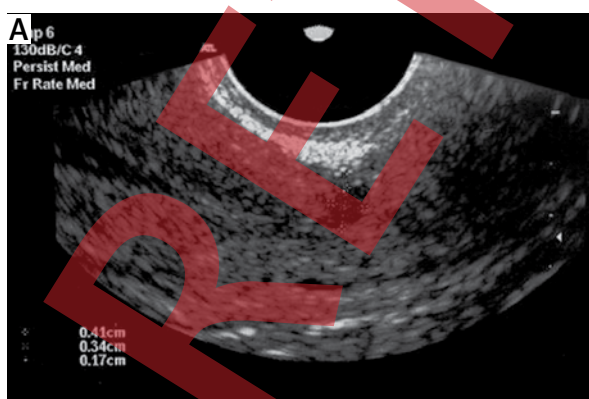


Photo 1. Patient 1 before and after surgery (day after surgery)

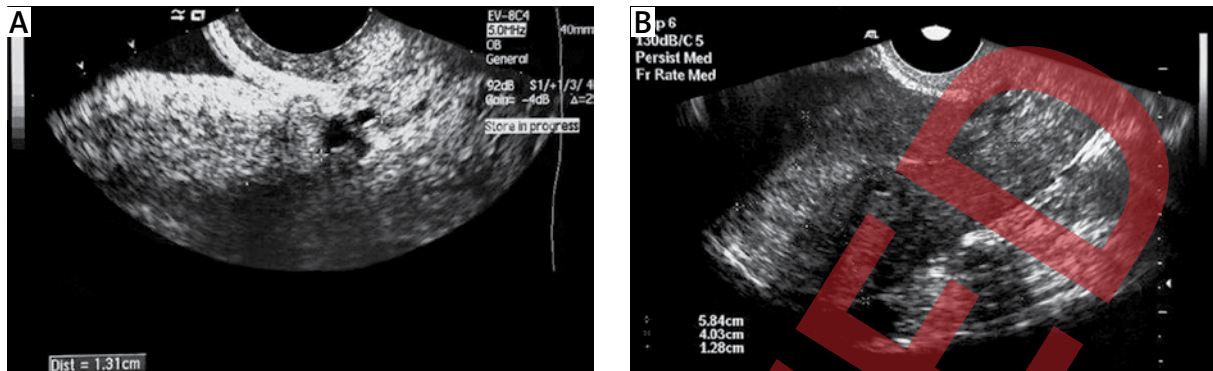


Photo 2. Patient 4 before and after surgery (day after surgery)

Table II. Symptoms before surgery, operation time, surgery effects

No.	Symptoms	Thickness before [mm]	Thickness after [mm]	Surgery time [min]	Pregnancy	AUB after surgery	PP after surgery
1	AUB	1.7	5.3	85	-	-	-
2	AUB	3	4.7	83	-	-	-
3	AUB, PP	2.5	7.1	110	-	-	+
4	AUB, PP	3	7.2	102	-	-	-
5	AUB, PP	1.5	5.2	105	-	-	-
6	AUB, SI	1.5	5.2	91	+	-	-
7	AUB, SI	1.5	6.1	104	-	+	-
8	AUB, SI	2.1	4.4	92	+	-	-
9	AUB, SI, PP	2.7	8.2	80	+	-	-
10	AUB, SI, PP	2.9	7	101	-	+	+
11	AUB, SI, PP	2.2	6.4	75	-	-	-
12	SI	2.4	6.1	95	+	-	-
13	SI	2.8	5.1	86	+	-	-
14	SI	2.1	5.1	85	+	-	-
15	SI	2.6	7.2	91	+ (blighted ovum)	-	-
16	SI	2.6	6.9	77	-	-	-
		2.32 ±0.54	6.08 ±1.11	91.38 ±10.38			

AUB – abnormal uterine bleeding, SI – secondary infertility, PP – pelvic pain.

be the first-line option [4, 12, 31–33, 47]. The hysteroscopic isthmocoele excision can only be planned when the patient does not plan further pregnancies [9, 48]. With the use of hysteroscopy the risk of pre- and intrapartum uterine rupture due to thinning of the myometrium increases. It is very important that the patient must be well informed about the use of effective contraception after the hysteroscopic excision. If the patient changes the decision and

wants to become pregnant in the near future, the corrective surgical treatment must be implemented. In our opinion in women with future reproductive plans laparoscopic correction seems to be the best approach. Therefore the preoperative talk should carefully explain the difference between surgical methods. There are several surgical approaches. Hysteroscopy and laparoscopy (or open surgery) techniques result in different postoperative wound

Table III. Pregnancies after surgery in secondary infertility group

No.	No. in Table II	Method of labor	Week	Sex [M/F]	Birth weight [g]	APGAR 1-min
1	6	V	38	M	3130	10
2	8	CS	37	M	2990	10
3	9	CS	38	F	3350	9
4	12	CS	38	F	3510	8
5	13	V	38	F	3250	10
6	14	N/A	20 week (continues)	N/A	N/A	N/A
7	15	D&C	10	N/A	N/A	N/A

CS – cesarean section, V – vaginal delivery, N/A – not applicable, M – male, F – female.

appearance. There are no reports comparing outcomes of these two surgical techniques, performed at the same facility, and there are no guidelines for the selection of operative strategies for infertility. Some authors present methods of transvaginal uterine scar treatment, but we do not have any experience with those techniques [49–51].

Authors from Japan have a surgery qualification strategy based on two criteria: residual myometrial thickness (RMT) and the position of the uterus. Due to the fact that the RMT less than 2 mm increases the risk of bladder injury and poses the risk of uterine rupture, hysteroscopic surgery is only indicated in women with RMT of > 2.5 mm [29, 34]. Retroverted uterus is associated with an increased risk of isthmocele; in those cases laparoscopy is the method of choice. The anteflexion of the uterus is maintained by shortening the round ligaments [20, 34]. When the two suggested criteria were adopted, 63.6% of patients achieved pregnancy. Pregnancies occurred in all patients from the hysteroscopy group (4 of 4). In the laparoscopy group it was 55.6% (10 of 18). In different studies most patients achieved pregnancy after laparoscopy [32, 34, 52]. We think that the use of RMT and the uterus position may be reasonable to select the best surgery method.

In our center laparoscopy is the method of choice, because of the good treatment results. This method ensures appropriate visibility during surgery; it is also less dangerous to adjacent organs. It ensures quick recovery and a relatively pain-free postoperative course with early return to normal function [53]. It is a universal method, both for gynecological disorders as abnormal bleeding or secondary infertility treatment and prevention in case of uterine rupture risk (by increasing the thickness of the uterus ante-

rior wall) [31, 32]. Our method is a partial modification of the method presented by Donnez *et al.* in 2008 [31].

Results obtained in our center are promising. In 9 (81.8%) of 11 women with abnormal bleeding we obtained complete resolution of symptoms. Compared to Schepker *et al.*, who operated on 5 patients with full resolution of symptoms, this is also a very good result [46]. We have slightly worse results in the case of pelvic pain. In 4 (66.6%) of 6 patients the pain resolved completely. Schepker *et al.* obtained exactly the same result [46]. Some patients can have pain symptoms for different reasons, usually unrelated to the scar defect. These can be adhesions, endometriosis and pain at the site of trocar insertion [12].

We consider the high number of pregnancies after laparoscopic treatment as an exceptional success. We have obtained 7 (63.6%) pregnancies in 11 patients operated on due to secondary infertility. Schepker's *et al.* obtained pregnancies in 60% of patients and Tanimura and his team 55.6% [34, 46]. All of the children were born in good general condition. Pregnant patients are described in Table III. Two cesarean sections were performed due to fetal distress during the labor (Table III, No. 3 and 4); one cesarean section was performed due to breech presentation in active labor (Table III, No. 2). The 2 vaginal births took place without any complications. None of the patients reported pain symptoms around the scar area during pregnancy and labor. New patients who are referred to our center are also operated on by this method; the results will be presented in subsequent publications.

Our results are encouraging. In our opinion laparoscopic treatment seems to be currently one of the most effective methods in isthmocele therapy,

especially in patient with multiple complaints such as pain, infertility or AUB. The main limitation of our study is the small number of cases. Like Schepker *et al.*, we cannot perform appropriate statistical analysis that would show the true effectiveness of our method [46]. Our study does not include a control group; patients with isthmocele who were not operated were only observed. We were not able to compare different methods of correction (laparoscopic versus hysteroscopic). Our findings should therefore be identified as clinical observations.

Conclusions

An appropriate diagnosis and a good preoperative strategy should be implemented all over the gynecological centers to increase the effectiveness of isthmocele treatment. Further investigations are necessary to determine the surgical indications, suitable treatment strategies, and appropriate care. Multicenter studies are necessary to assess the effectiveness of individually applied therapies. Appropriate treatment schemes, depending on the clinical situation, should be developed to apply the best solution. The presented laparoscopic technique allows the complete correction of isthmocele and improves patient well-being. Laparoscopic isthmocele removal is a method of treatment which provides repeatable good results. Early scar defect identification in non-pregnant women and appropriate treatment can contribute to the prevention of uterine rupture and better pregnancy outcomes, as well as resulting in resolution of isthmocele dependent symptoms. Laparoscopy has a great chance to become a leading technique in isthmocele therapy during the forthcoming years.

Conflict of interest

The authors declare no conflict of interest.

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