



AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

Formerly The American Fertility Society

1209 MONTGOMERY HIGHWAY • BIRMINGHAM, ALABAMA 35216-2809 • TEL (205)978-5000 • FAX (205)978-5005 • E-MAIL asmr@asmr.com

PATIENT'S FACT SHEET INTRAUTERINE ADHESIONS

Trauma to and/or infection of the uterine lining (endometrium) may lead to the formation of intrauterine adhesions or destruction of the endometrial lining. Intrauterine adhesions are defined as scar tissue inside the uterine cavity.

Causes: The principle cause of intrauterine adhesions is trauma to the uterine cavity. This may occur following dilation and curettage (D&C), an outpatient surgical procedure during which the cervix is dilated and the tissue contents of the uterus are emptied. D&C may be performed for excess uterine bleeding after childbirth, pregnancy termination, or other gynecological conditions. Less commonly, prolonged use of an intrauterine device (IUD), infections of the endometrium (endometritis), and surgical procedures involving the uterus (such as removal of fibroids) may also lead to the development of intrauterine adhesions.

Symptoms: Women with intrauterine adhesions may have no obvious problems. Many patients, however, may experience menstrual dysfunction in the form of absent, light, or infrequent menstruation. Also, they may be unable to achieve pregnancy, or experience recurrent miscarriages. Less commonly, pelvic pain or dysmenorrhea (painful menstrual periods) may be present.

Diagnosis: Hysterosalpingography (HSG), an x-ray procedure, is a common method used to diagnose intrauterine adhesions. During an HSG, a solution is injected into the uterus to illustrate the inner shape of the uterus and determine if the fallopian tubes are open. Hysteroscopy is also used to diagnose intrauterine adhesions. This is a procedure in which a thin, telescope-like instrument is inserted through the cervix to allow direct visualization of the uterine cavity. Although HSG is a useful screening test, hysteroscopy is the most accurate method of evaluating intrauterine adhesions. Both HSG and hysteroscopy can be performed in an office setting without general anesthesia.

Treatment: Surgical removal of intrauterine adhesions with hysteroscopic guidance is generally recommended. Following removal of the adhesions, many surgeons recommend temporarily placing a device, such as a plastic catheter, inside the uterus in an effort to keep the walls of the uterus apart and prevent adhesions from reforming. Hormonal treatment with estrogens and progestins, and non-steroidal anti-inflammatory medications, are frequently prescribed after surgery to lessen the chance of adhesion reformation.

Reproductive Outcome: Reproductive outcome appears to correlate with the type and extent of the adhesions. After treatment, patients with mild to moderate adhesions have full-term pregnancy rates of approximately 70 to 80 percent, and menstrual dysfunction is frequently alleviated. Alternatively, patients with severe adhesions or extensive destruction of the endometrial lining may only have full-term pregnancy rates in the 20 to 40 percent range after treatment. Women with extensive damage to the endometrium unresponsive to conventional therapy by hysteroscopy may be offered gestational surrogacy.