



Adhesion Barrier Gel for Intrauterine Surgery

CASE REPORT

Septate Uterus, Intrauterine Adhesions, and Pelvic Endometriosis

A 40y/o with a septate uterus and a history of miscarriages underwent a hysteroscopy followed by the application of Oxiplex® IU Gel.

She became pregnant and carried to term.



Dr. William Kondo

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- Gynecological surgeon focusing on minimally invasive laparoscopic procedures.
- Recognized endometriosis specialist.
- Studied pelvic reconstruction surgery at The Cleveland Clinic, Florida, United States.
- Studied gynecological endoscopy in Strasbourg and Clermont-Ferrand, France.
- An active member of the Brazilian Society of Minimally Invasive and Robotic Surgery and the Brazilian College of Surgeons.

Case Introduction

- 40 y/o referred for laparoscopic cerclage due to isthmocervical incompetence.
- Three previous hysteroscopies for treatment of uterine septum and intrauterine adhesions.
- Three miscarriages.
- One premature birth at 21 weeks.

Case Presentation

The patient had symptoms of dysmenorrhea 4/10, with no other associated painful symptoms (dyspareunia, non-cyclical pelvic pain).

Previous history of 3 hysteroscopy procedures for the treatment of uterine septum and intrauterine adhesions. Three previous miscarriages, 2 of them at 15-16 weeks of gestation and another at 8 weeks. A premature birth at 21 weeks of gestation led to consideration of isthmocervical incompetence. There was a diagnosis of dilation (during a routine ultrasound) of the internal cervical os with protrusion of the amniotic sac.

A transvaginal ultrasound showed a cervix longer than 30mm with a normal uterus and ovaries, with no signs of deep endometriosis.

At the end of the consultation, a surgical procedure was indicated to evaluate the uterine cavity by hysteroscopy associated with a laparoscopic procedure to perform a pre-gestational cerclage.

Septate Uterus, Intrauterine Adhesions, and Pelvic Endometriosis



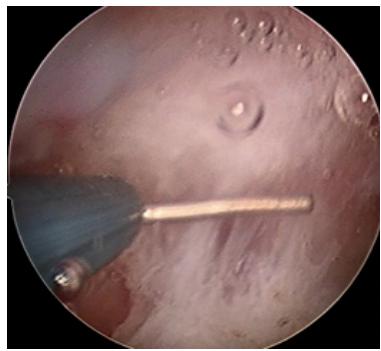
fzioMed

10 mL

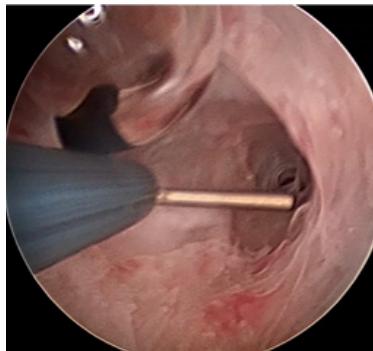
CASE REPORT

Surgical Procedure

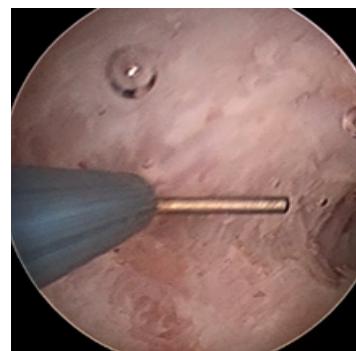
During the hysteroscopy, adhesions were identified in the uterine cavity, as well as residual fundic septation. Adhesion lysis was performed as well as hysteroscopic metroplasty using a Gubbini mini-resectoscope.



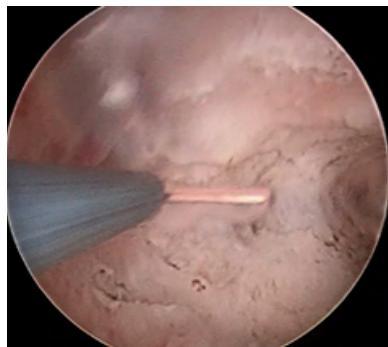
Lysis of uterine adhesion in the uterine fundus.



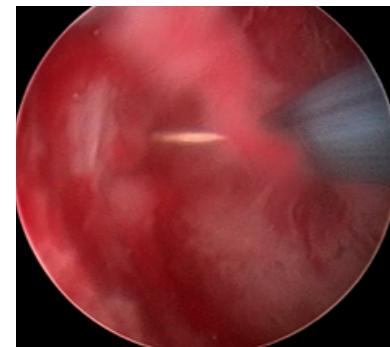
Lysis of uterine adhesion on left side.



Lysis of uterine adhesions on left side, and fundal metroplasty.



Fundal metroplasty



Lysis of adhesions on right lateral wall, obliterating the right tubal ostium.



Lysis of dense adhesion on left lateral wall, obliterating the left tubal ostium.



Lysis of adhesion on right cornual region, obliterating the right tubal ostium.

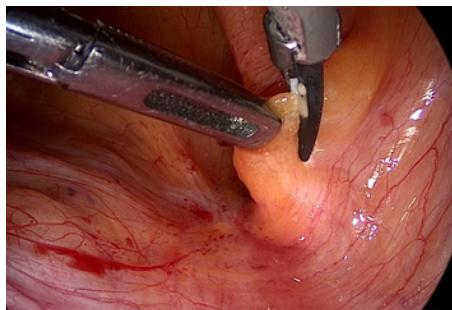
Septate Uterus, Intrauterine Adhesions, and Endometriosis



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Surgical Procedure

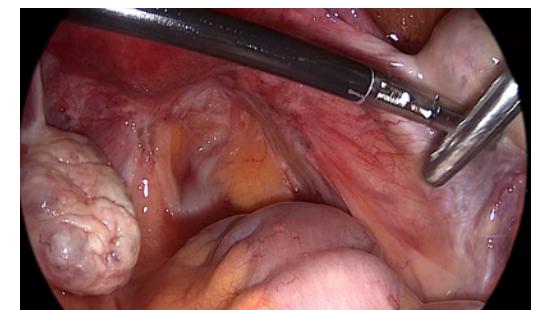
Using the laparoscope, deep endometriosis were identified in multiple sites (ovarian fossae, uterosacral ligaments, rectovaginal septum, and superficially anterior wall of the rectum). Endometriotic implants were resected in ovarian fossae, uterosacral ligaments, rectovaginal septum, rectal shaving, and laparoscopic cerclage. The surgical procedure lasted 85 minutes, with an estimated blood loss of 20 ml. The hospital stay was 21 hours. Postoperative evaluation was satisfactory, with return to work activities in 10 days.



Endometriotic implants in the right anterior cul-de-sac.



Endometriotic implants in the left anterior cul-de-sac.



Endometriotic implants of the right ovarian fossa, retrocervical region, rectovaginal septum and anterior wall of rectum.



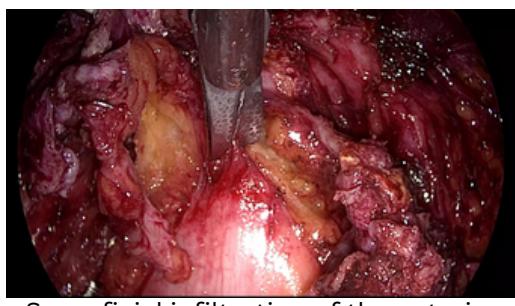
Endometriotic implants in the left ovarian fossa and left uterosacral ligament.



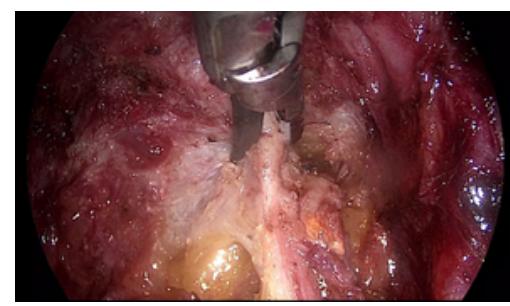
Endometriotic implants in the left retrocervical region and left uterosacral ligament.



Endometriotic implants in the left ovarian fossa and left uterosacral ligament.



Superficial infiltration of the anterior wall of the rectum.



Resection of implants retrocervical and in rectovaginal septum.

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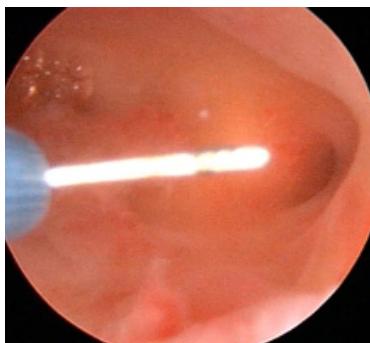


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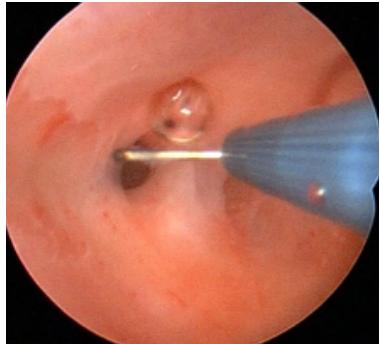
Final Surgical Procedure

Surgical hysteroscopy using a Gubbini mini-resectoscope

Due to the presence of intrauterine adhesions seen during the previous procedure, another hysteroscopy was performed 40 days later to review the uterine cavity. The procedure identified residual adhesions in the left lateral wall and right uterine fundus, which were resected again with a Gubbini mini-resectoscope. At the end of the procedure, **10mL of Oxiplex® IU gel** was applied inside the uterine cavity to minimize reformation, as well as the formation of future adhesions.



Lysis of residual adhesion on left side of uterus.



Lysis of residual adhesion on right side of uterus.

Lysis of residual adhesion on the right side of uterus and in the uterine fundus.

Follow-up Discussion

In this case report, we demonstrate the application of **Oxiplex®IU** after a hysteroscopic surgical procedure for lysis of residual adhesions in a patient with a previous history of 3 hysteroscopies for the treatment of uterine septum and intrauterine adhesions. Initially, the patient underwent hysteroscopy for routine fertility evaluation along with the surgical procedure to perform prepregnancy cerclage due to isthmocervical incompetence. During the hysteroscopy procedure, the presence of intrauterine adhesions and residual fundal septation was identified and treated. During laparoscopy, the presence of deep endometriosis was identified and surgically removed. For the last, most recent hysteroscopy procedure, the use of **Oxiplex IU** (carboxymethylcellulose and polyethylene oxide) was used to reduce the recurrence of intrauterine adhesions.

After this last procedure, the **patient became pregnant and carried the pregnancy to term**. Thus, we highlight the effective clinical outcome of using an anti-adhesion product such as Oxiplex IU in intrauterine surgeries to improve the reproductive function of patients.