Isthmocele management in infertile patients - Olivier Donnez (France)

Q: When you do a SC after a laparoscopic repair, are there more risk of bladder lesions?
A: Thank you for your question. In our experience, this risk is not higher after CSD repair and to my knowledge, not described in other series.

Q: What challenges will one face in a repeat C-section in those who have had lap repair?
A: Thank you for your question. In all Cs performed after CSD repair, the inferior uterine segment was normal and Cs were not challenging.

Q: Indication for repair is sec. infertility. Us it the same if the first pregnancy was IVF?
A: This is an excellent question! In this particular indication (and if the CSD is asymptomatic), we do not know if the CSD is related to infertility. So my advice would be, max of 2 IVF attempts and if no pregnancy, CSD repair according to RMT. However, of the RMT is less than 3mm, the risk of uterine rupture should be discussed according the literature as well as the Cs scar pregnancy.

Q: What should be the interval between isthmocoele surgery and embryo transfer and do u prescribe any antibiotics after repair?
A: Thank you for your question. Three months after repair, we recommend performing MRI or Ultrasound examination of the repair. If imaging is satisfactory, as well as symptom relief, embryo transfer is allowed.

Q: Why antevert/axial the uterus with round ligament sutures? Many women with retroverted uterus conceive naturally.
A: Thank you for your question. It is not a question of natural conception but as retroverted uterus is one of the risk factors for CSD, this situation could increase the tension on the sutures. This is why we propose uterine antefixation in case of retroverted uterus with CSD.

Q: Is there an advantage when you are going to do IVF/ICSI (for a different reason) to still perform the repair? For example for embryo transfer
A: Thank you for your question. Excellent question. In this case, we do not know if CSD is associated with infertility. I will not recommend to correct all the CSD in this indication. However, we must
consider surgery after 2 IVF failure, in case of deep CSD (a transfer test can be performed to evaluate feasably) or very thin RMT (risk of uterine rupture according to the literature).

Q: Do you find some patients initially improve and symptoms recur later, or is failure of procedure immediate?
A: Thank you for your question. In my experience, when failure happened, symptoms recurred very soon

Q: How do you differentiate between and defect that needs treating and one that doesn't?
A: Thank you for your question. I published an algorithm in Fertility and Sterility (https://www.fertstert.org/article/S0015-0282(20)30083-2/fulltext). Briefly, asymptomatic women with no pregnancy desire should not be treated. OP and P could be used in symptomatic patients with no pregnancy desire. Symptomatic patient with pregnancy desire should be treated according to RMT measurements.

Q: Do you take presence or absence of fluid in the uterine cavity (not in the defect) into account when deciding whether to do surgery or not?
A: Thank you for your question. No, because fluid is highly variable from patient to patient and from day of the cycle.

Q: Have you got cervical stenosis in patients after the surgery?
A: Thank you for your question. No, never. We insert a Hegar probe in the cervix before suturing in order to avoid cervical stenosis.

Q: What is the risk of cervical insufficiency after hysteroscopic resection of the isthmocoele?
A: Thank you for your excellent question. To my knowledge, there is no association between hysteroscopic repair and cervical insufficiency. Even if the series are small, I do not think that there could be an association because the CSD are usually up to the internal os. However, we must be careful when the CSD is located very low. Cervical length monitoring could be indicated in this case.

Q: Do you see recurrence of isthmocele (say after 1 year) in case of failure to conceive?
A: Thank you for your question. As we propose MRI 3 months after surgery, recurrence are immediately noticed.

Q: The mode of delivery after Hysteroscopic resection for an isthmocele should be obligatory a cesarean or it may be vaginal delivery also?
A: Thank you for your question. If post-operative RMT is more than 3mm, vaginal delivery can be considered after hysteroscopic correction. When RMT is less than 2.5mm, there is a 9.1% risk of uterine rupture. In this situation, Cs should be recommended.

Q: Do you think the repair of isthmocele should be somehow centralized in European level? Some expert centers?

A: Thank you for your question. This is a difficult question to answer. A lot of physicians do not even think that CSD could exist and these are only ultrasound picture without any significance. The technique must be standardized, and the indications have to be recognized.

Q: What is cause of this defect?

A: Thank you for your question. The way of suturing is apparently not related to CSD except for locked running suture during Cs. Several risk factors have been identified such as the number of Cs, retroverted uterus, Cs performed in advanced labour (more than 5 hours and more than 5cm cervical dilatation), diabetes, high BMI and peripartal infection.

Q: Why do you correct the retro into anteversion of the uterus? what are the side effects? For example pain during pregnancy?

A: Thank you for your question. We do this correction to decrease the tension on the suture after CSD repair, as retroverted uterus is a recognized risk factor for CSD. This simple surgical procedure often performed in case of Douglas pouch endometriosis is not associated with pain during subsequent pregnancy. Aponeurotic pain can be present after surgery but usually passed away with anti-inflammatory painkillers.

Q: What can we do to prevent of creation isthmocele?

A: Thank you for your question. I think we cannot for the moment. However, we know that risk of CSD is increased when Cs is performed in advanced labour with low incision. In this case, perform a high incision could prevent CSD. For other risk factors (number of Cs, retroverted uterus, Cs performed in advanced labour (more than 5 hours and more than 5cm cervical dilatation), diabetes, high BMI and peripartal infection), we can detect CSD sooner.

But the best way to prevent CSD would ideally be decreasing CS rates...

Q: Your hysteroscopic approach you are just resecting without restoring the defect. This might make the defect larger rather than approximate it.

A: Thank you for your question. Hysteroscopic treatment is a resection and not a correction. The goal is not approximate the edges but to resect the edges in order to facilitate blood flow during menstruations. This procedure reduces also inflammation resulting pain and spotting correction. If the edges need to be approximate (when RMT is less than 3mm), laparoscopic (or vaginal) repair is mandatory.
Q: What suture size and type do you use for microsurgery (tubal eversion, salpingostomy)?
A: We usually use monofilament 5 to 7x0 (5x0 is easier to manage, and 7x0 quite small therefore 6x0 monofilament seems a good compromise).

Q: When do you check for tubal patency after reanastomosis surgery and what modality of diagnosis do you use?
A: We perform tubal patency test 6 months after surgery if no pregnancy occurred. We do as a first line hysterosonography (which is better accepted) and if there is any doubt we ask for hysterosalpingogram.

Q: A lot tubal pathology in Africa and IVF too expensive you need to come and train surgeons here to help our women!
A: You are right IVF is too expensive in many countries and tubal surgery is a “cheaper” alternative in some cases. My team and myself are offering some training in Lyon but we may explore together the possibilities to offer “in situ” teaching and training (You may contact me: watrelot@watrelot.org).

Q: What success chances do you give to the patient after tubal reanastomose (will that salpenks be functional and can we guaranty no extrauterine)?
A: If performed by robots or “conventional” microsurgery, the patency is around 90% but the pregnancy rate depends mainly on the patient age (for example after 40, pregnancy rate is only around 30%). Performed by laparoscopy (which is quite challenging) the patency rate is around 70% with the same limitation due to the age of the patient. Ectopic pregnancy rate is low (3-5%) but always present. Unfortunately there is no guarantee to avoid ectopic (even during IVF even if this eventuality is rare).

Q: Any need to keep a stent inside the tube?
A: Never! It may be useful during the anastomosis but we recommend to remove it immediately after completion due to the risk to damage the inner epithelium of the tube.