Universidad del País Vasco
Euskal Herriko Unibertsitatea

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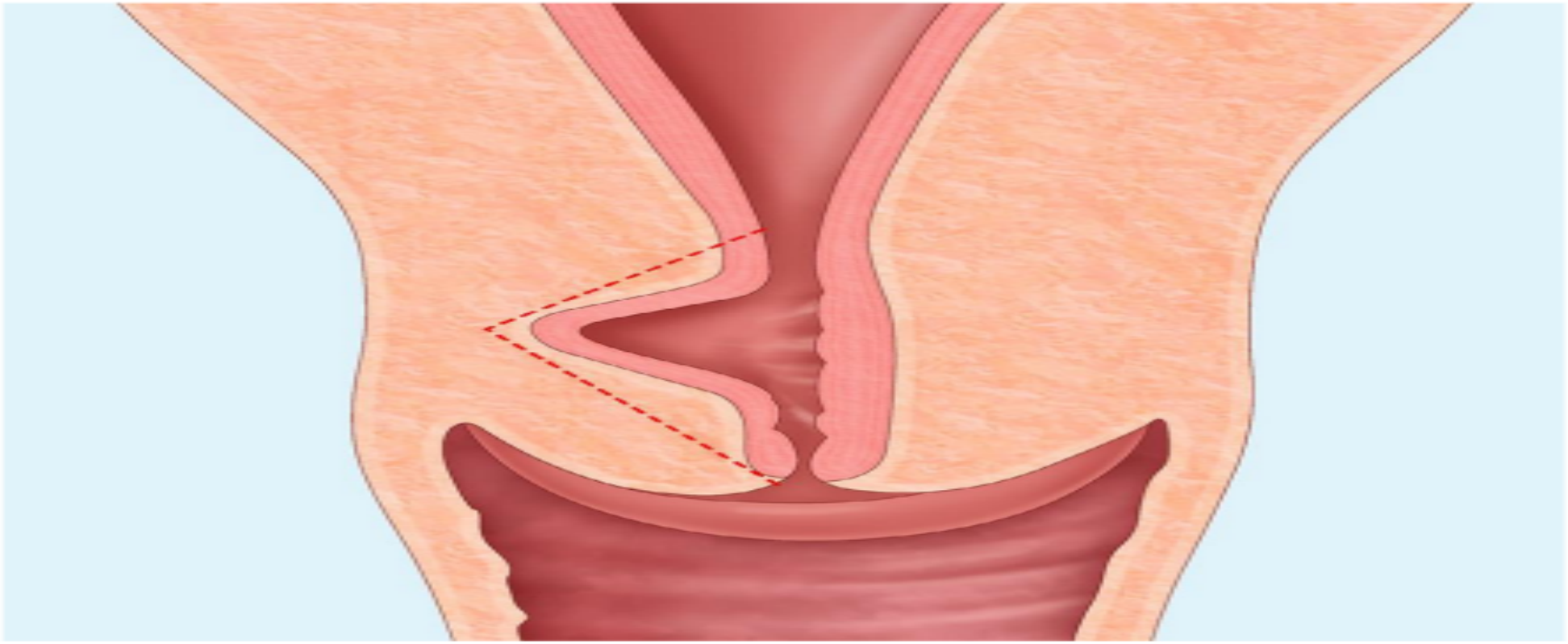
ISTMOCELE

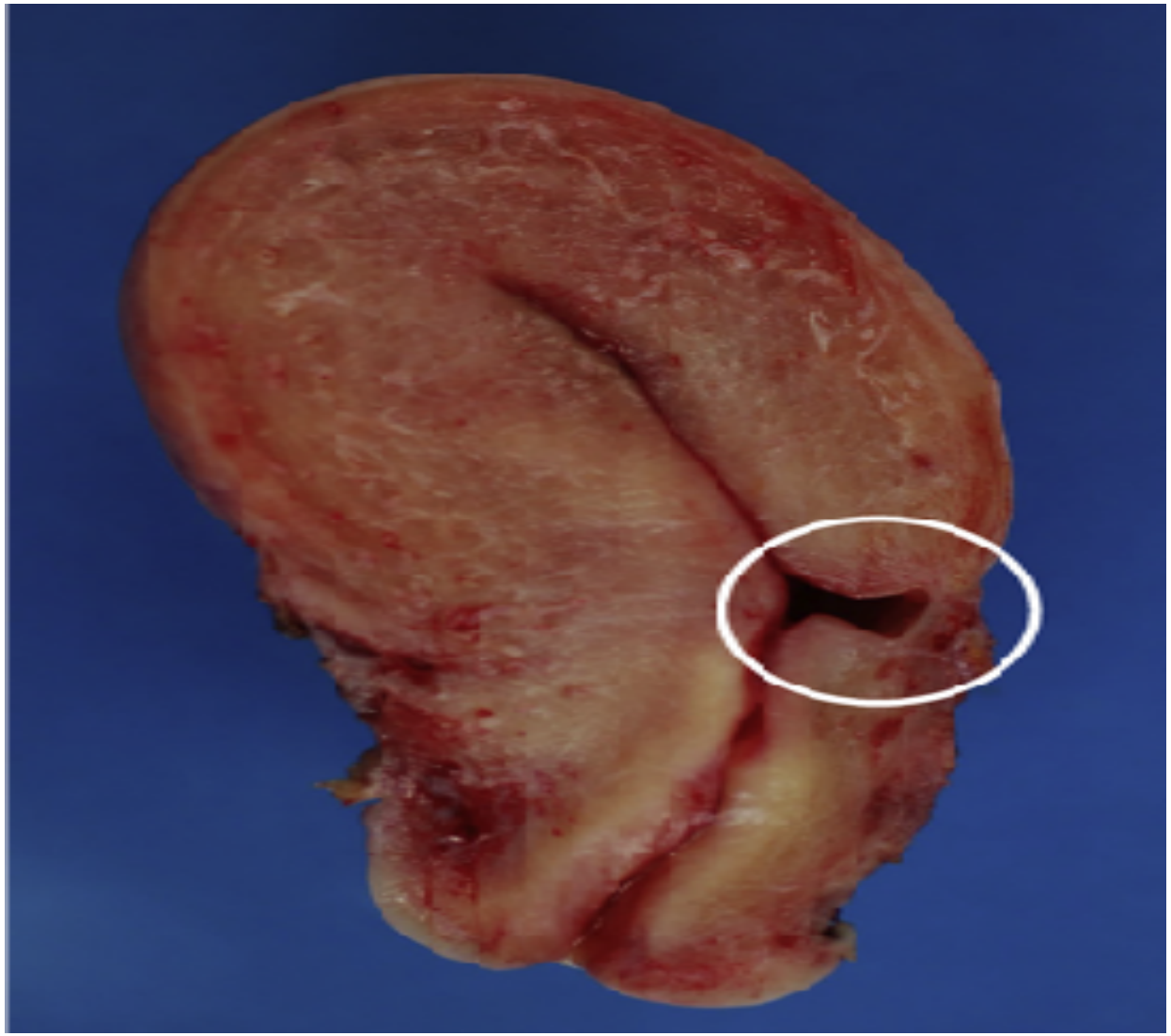
Aintzane Rabanal Nuñez

Gurutzetako Unibertsitate Ospitalea

EHU-UPV



Divertículo/nicho/pouch en la cicatriz de la cesárea
Identación interna con **defecto/adelgazamiento miometrio residual**



- Acumulación secreciones y **proceso inflamatorio**

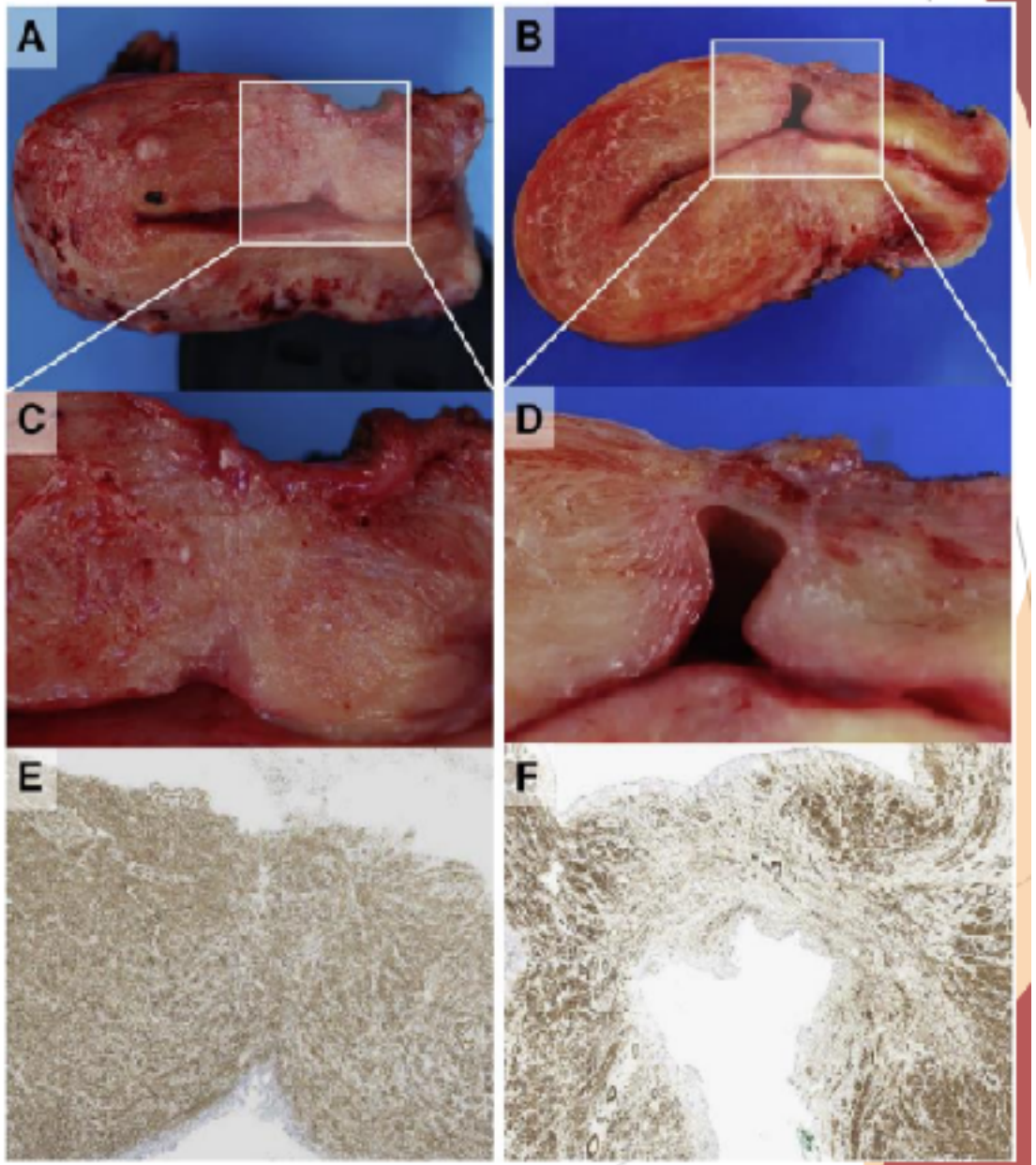
Factores de riesgo y protección

Factores de riesgo

- **Número cesáreas previas**
- Cesárea en trabajo de parto avanzado
- Incisión de histerotomía baja
- Sutura de histerorrafia simple, cruzada
- Retroversión uterina
- Infección periparto
- Obesidad
- Diabetes
- Hipercoagulabilidad

Factores protectores

- Antibioterapia
- Ácido α-lipoico
- Incisión de histerotomía alta
- Sutura de histerorrafia doble, no cruzada
- Sutura monofilamento



Frequency and associated symptoms of isthmoceles in women 6 months after caesarean section: a prospective cohort study

P. Gozzi[1] · K. A. Hees[1] · C. Berg[2] · M. David[1] · K.-D. Wernecke[3] · L. Hellmeyer[2] · D. Schlembach[4]

Conclusion The prevalence of isthmoceles 6 months after CS was 44.4%. Additionally, scar pain and lower abdominal pain were more pronounced when an isthmocele was also observed in the TVS.

Trial registration Trial registration number DRKS00024977. Date of registration 17.06.2021, retrospectively registered.

Archives of Gynecology and Obstetrics
https://doi.org/10.1007/s00404-022-06822-8

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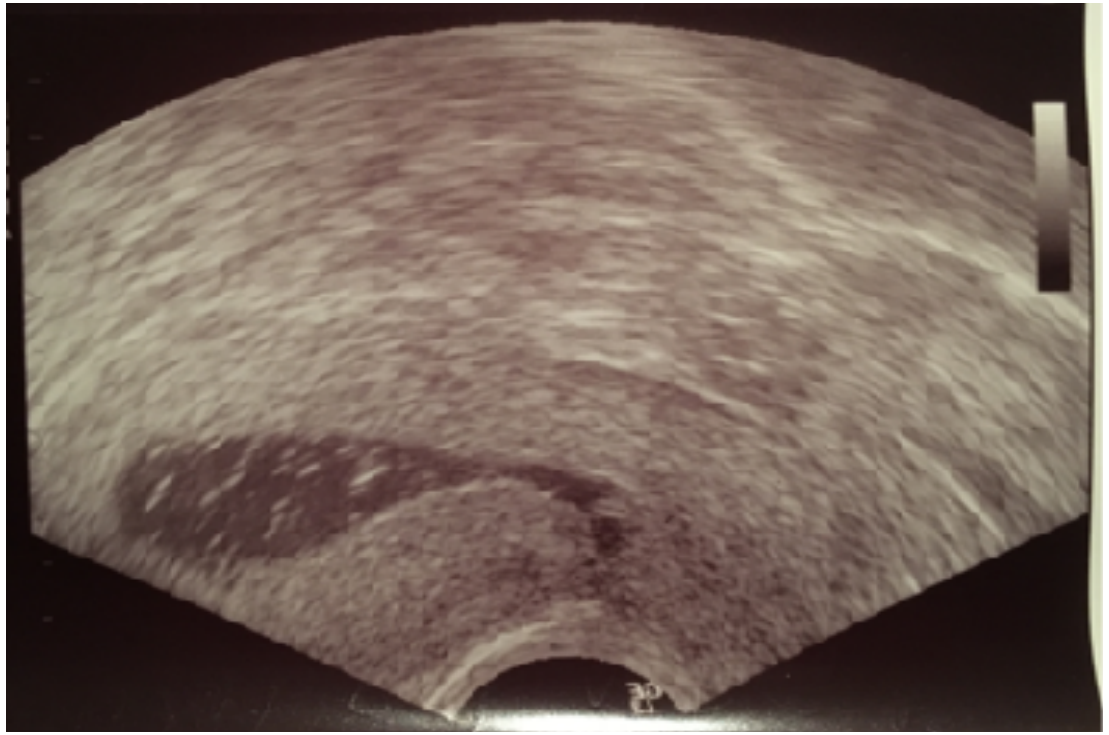
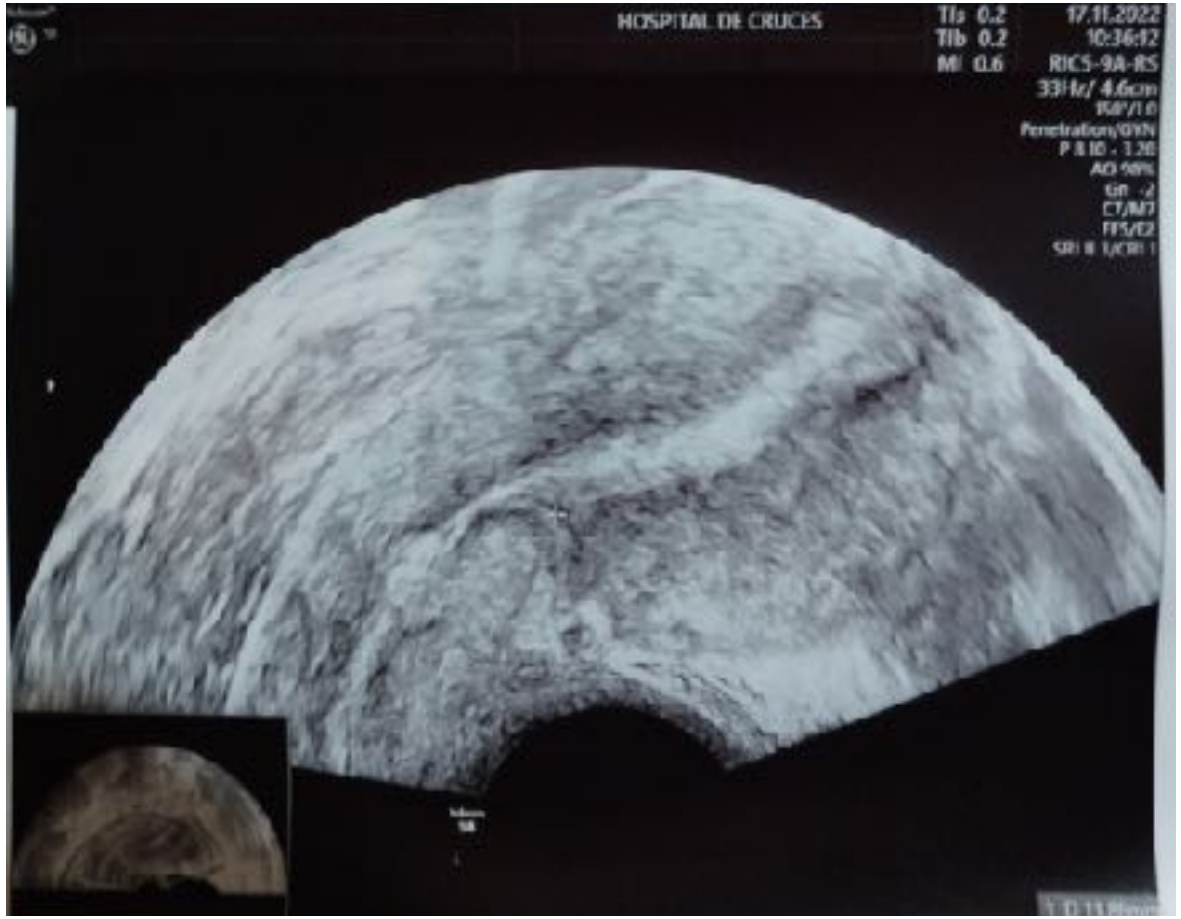
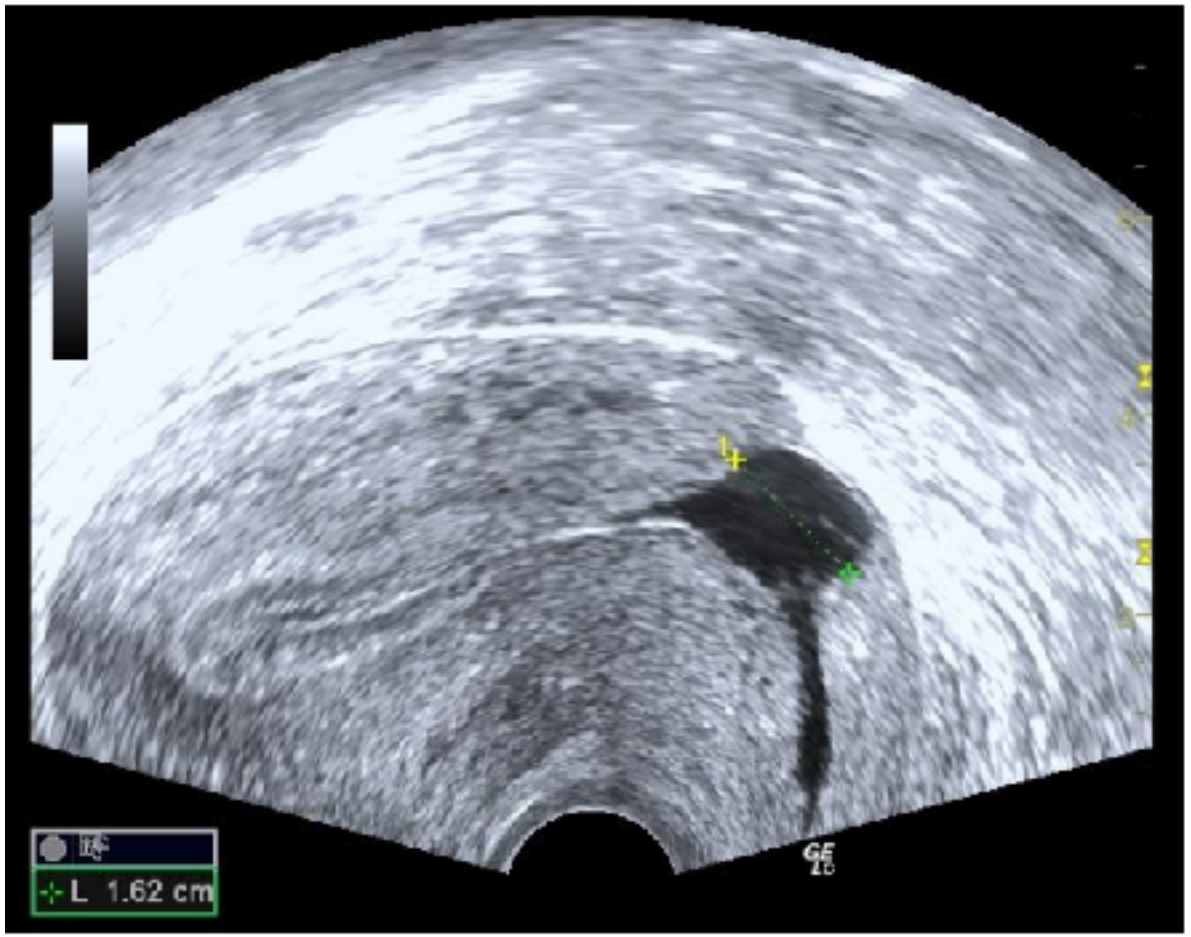
- Revisión retrospectiva (2018-2020)
- Determinar la frecuencia de istmocele en pacientes que han realizado tratamiento FIVTE/ ICSI en URH últimos dos años con antecedente cesárea (s)
- 13/35 → 37,14%

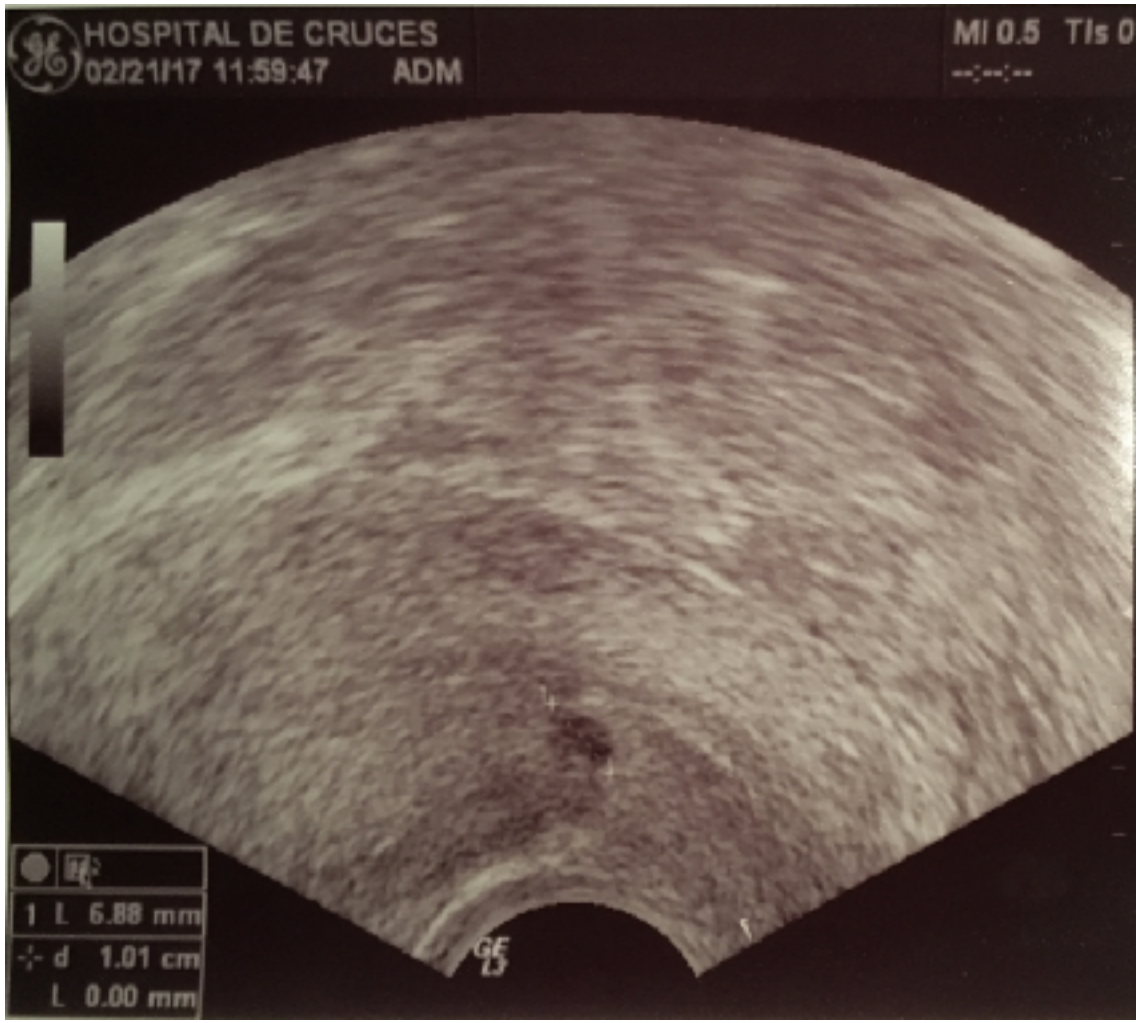


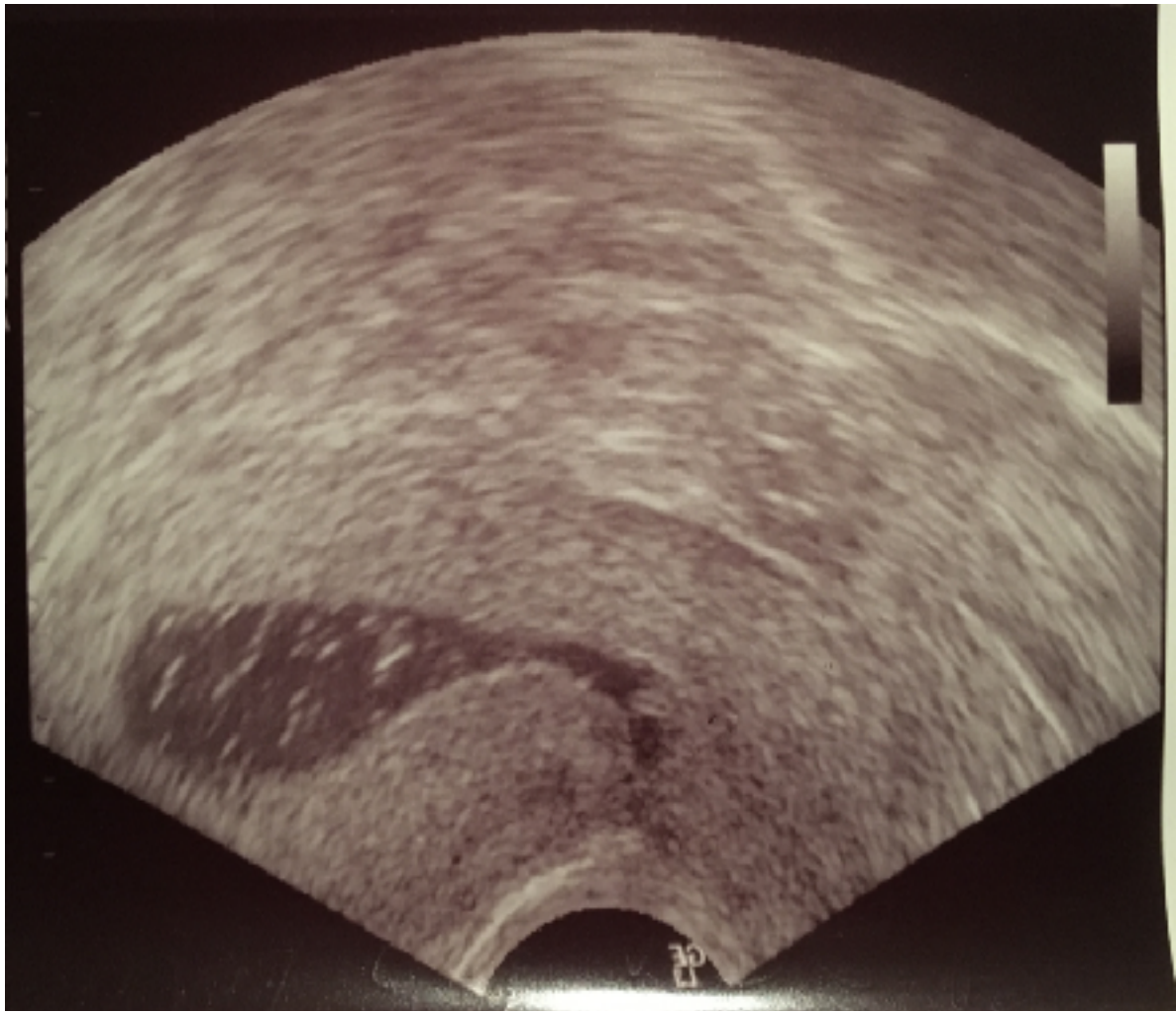
Diagnóstico



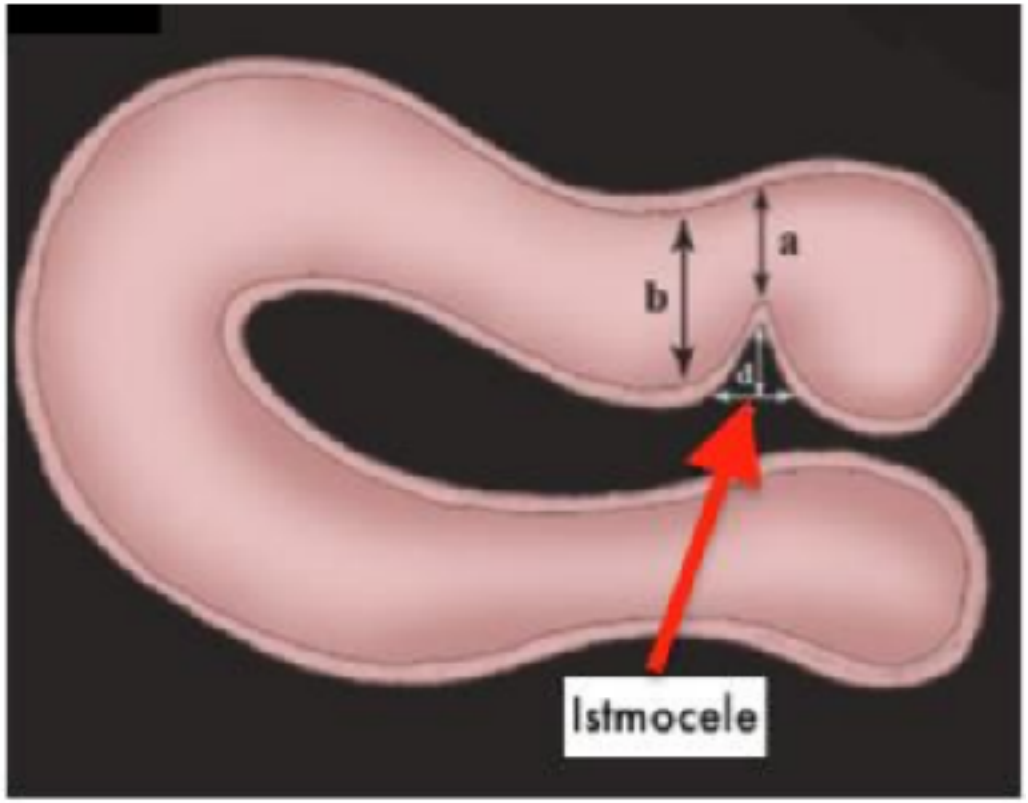


Diagnóstico

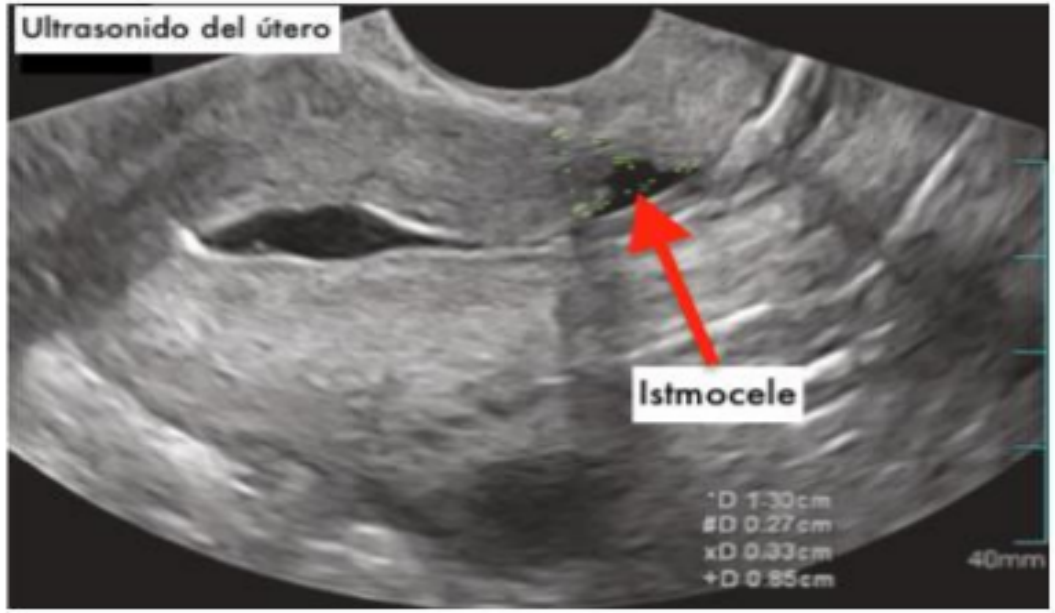


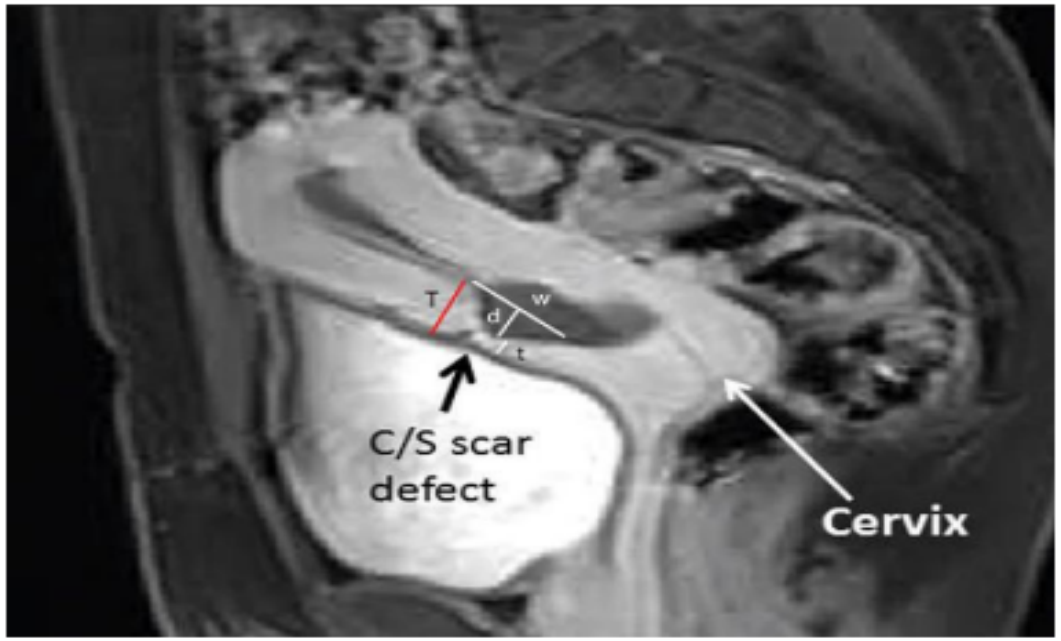


Diagnóstico



GROSOR MIOMETRIO RESIDUAL
2,5 MM





Perfiles clínicos

AP de cesárea

Sangrado post menstrual
Dolor

Manejo istomocele gestante

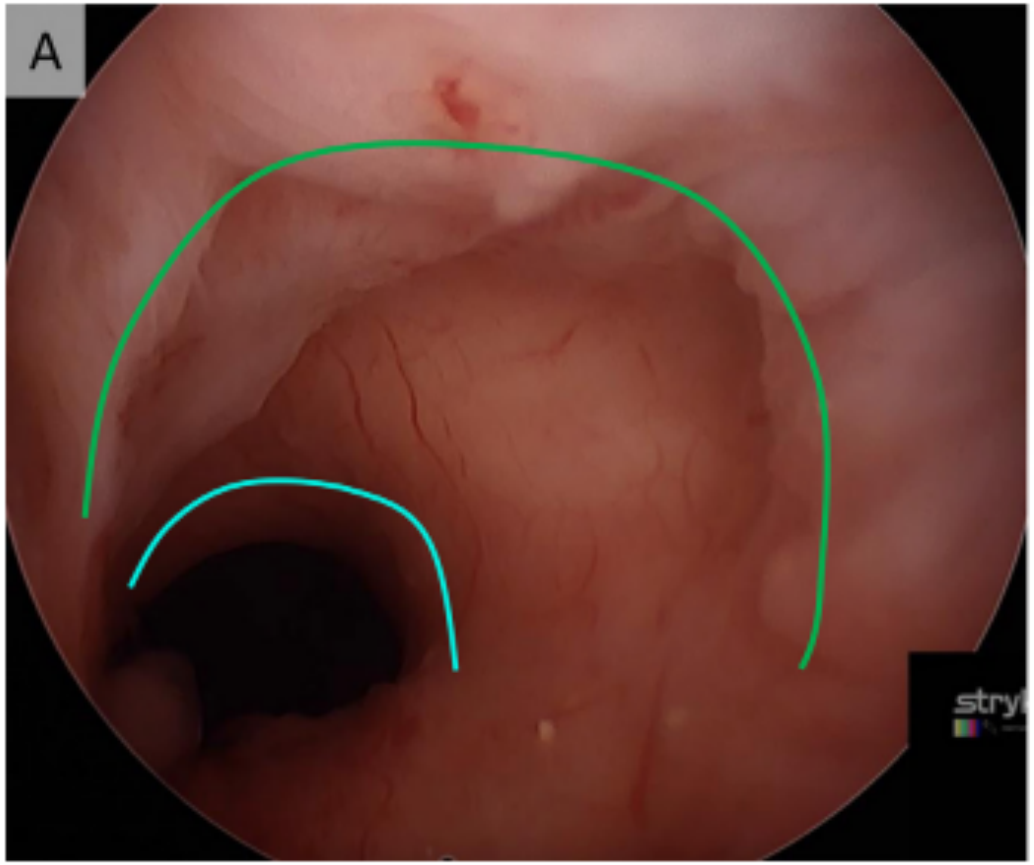
AP de cesárea

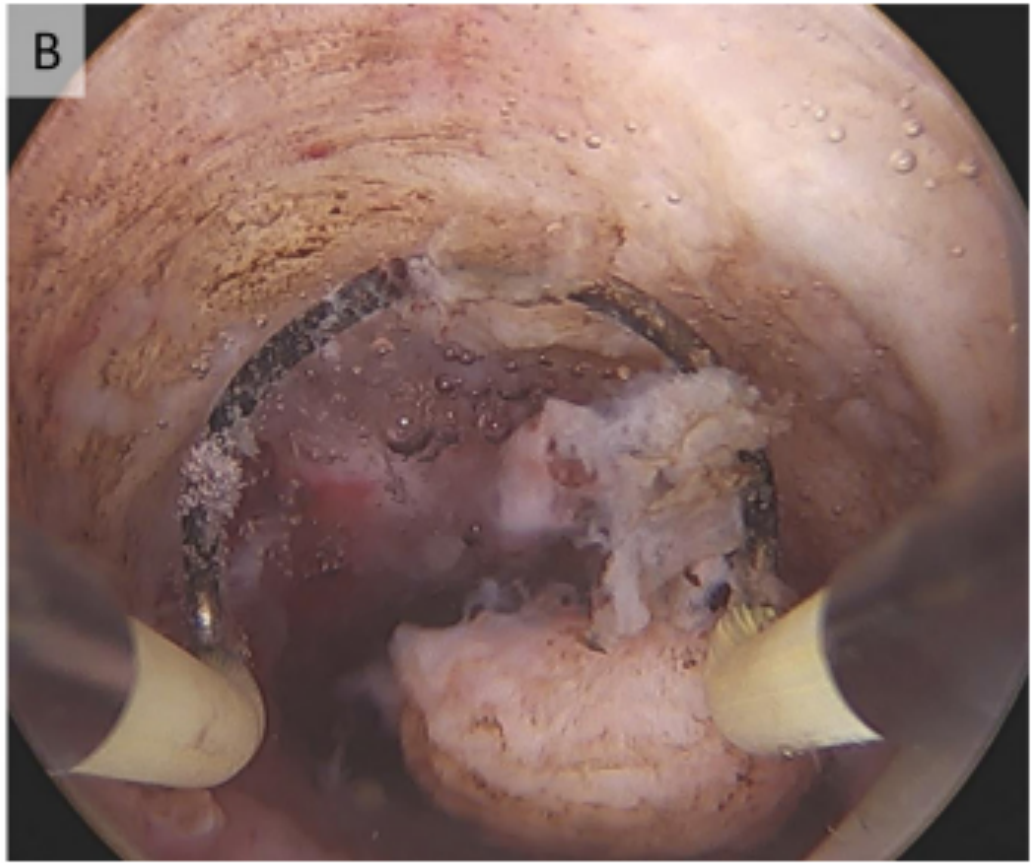
Subfertilidad secundaria

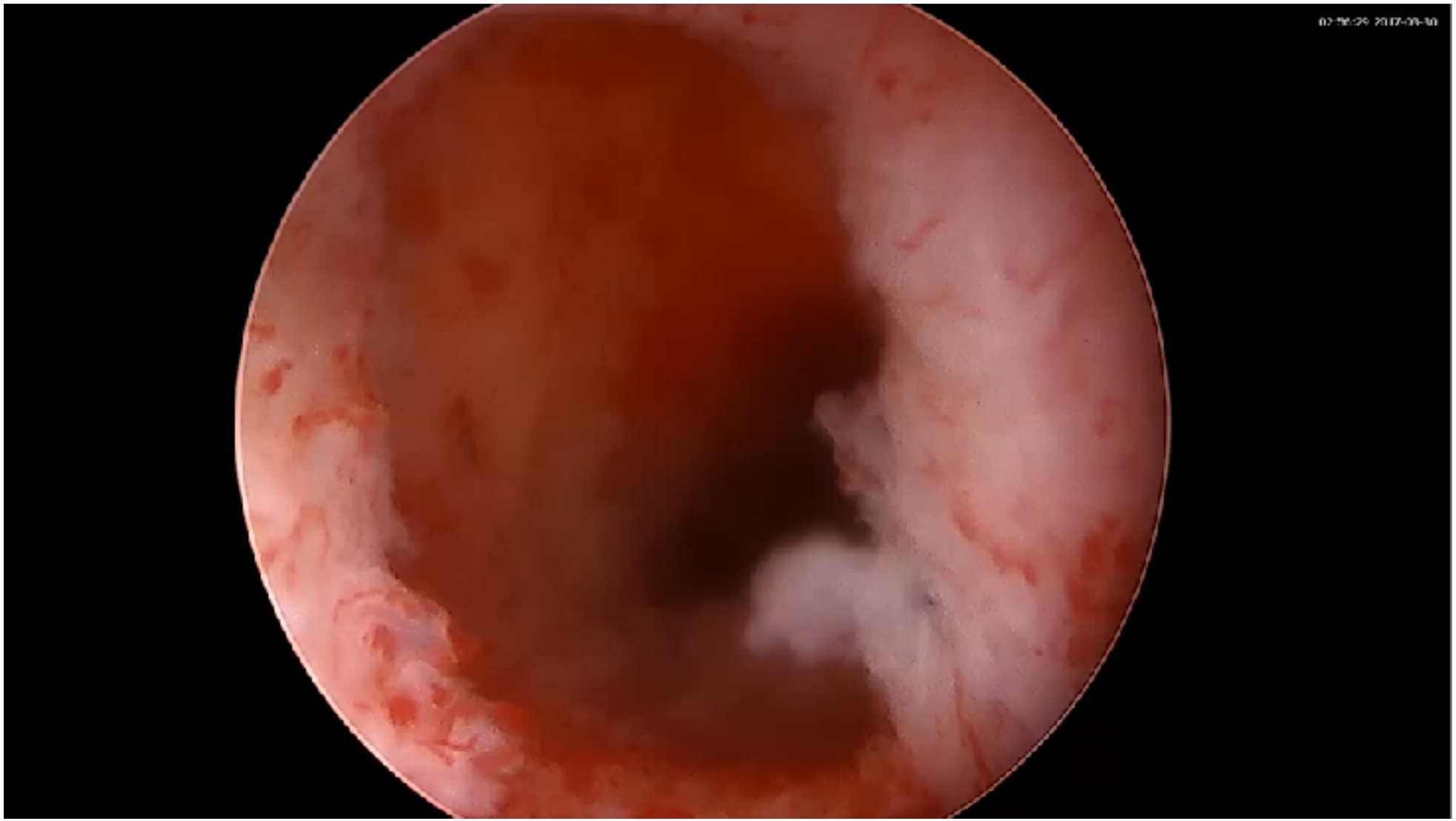
Tratamiento

- **Manejo expectante**: asintomático
- **Tto médico hormonal** (ACO, DIU hormonal…): sintomático (80% mejora SUA?), no deseo gestacional
- **Tto quirúrgico**: sintomático +- fracaso/contraindicación tto médico, deseo gestacional
  - **Plastia/remodelación histeroscópica**
  - **Resección/reparación laparoscópica**(/robótica) >vaginal (>laparotómica)
  - Histerectomía: fracaso tto, patología concomitante, no deseo gestacional

Tratamiento: Abordaje histeroscópico







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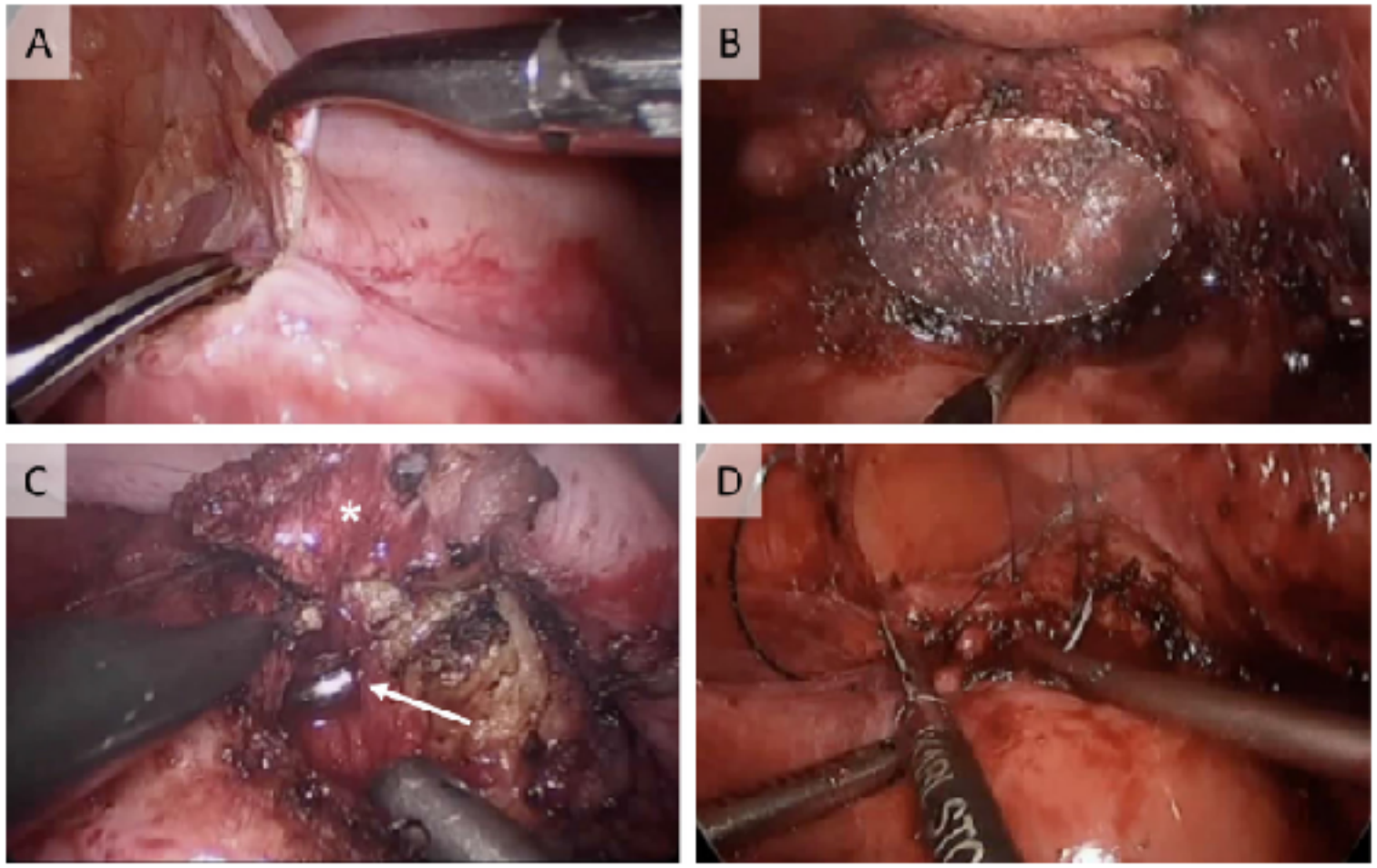
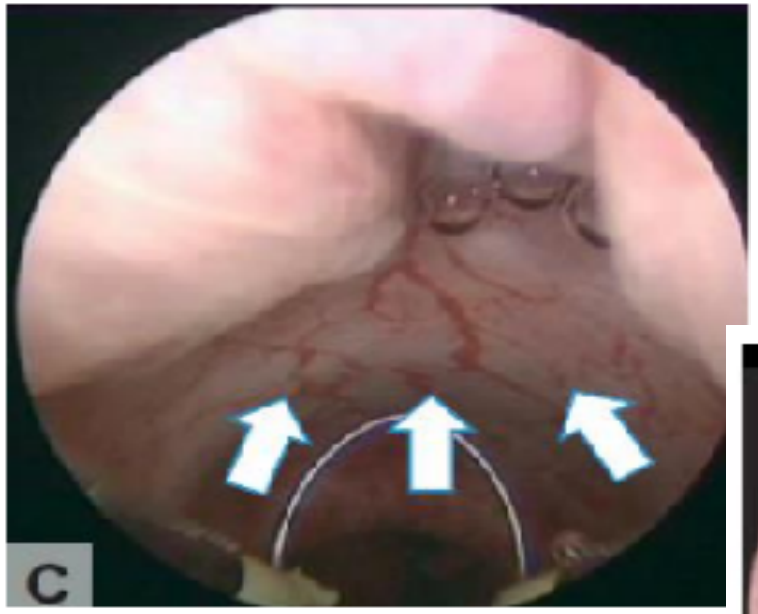
Tratamiento: abordaje laparoscópico



Dr Díez-Lázaro, HU Cruces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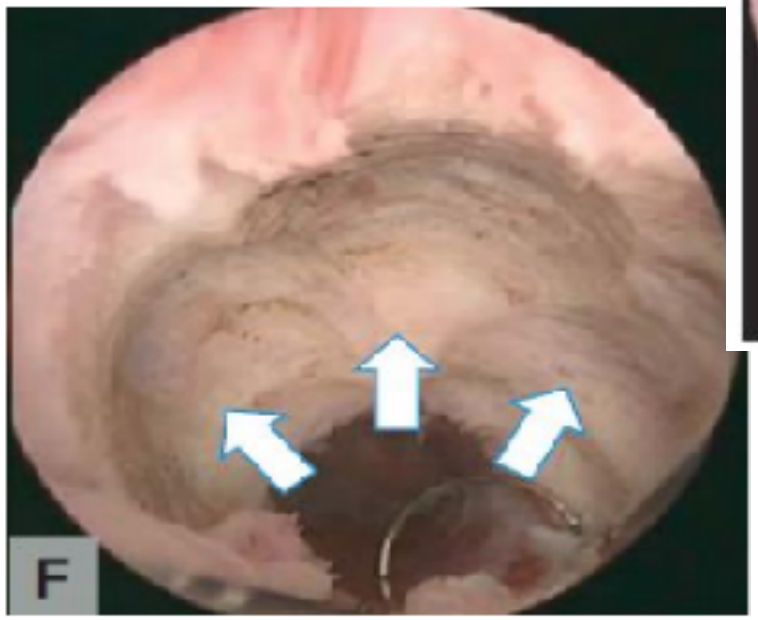
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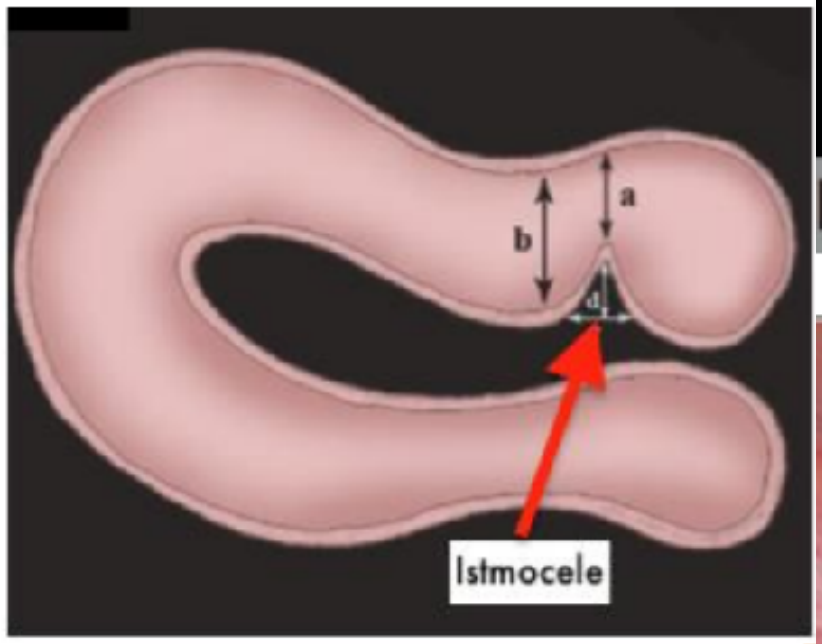
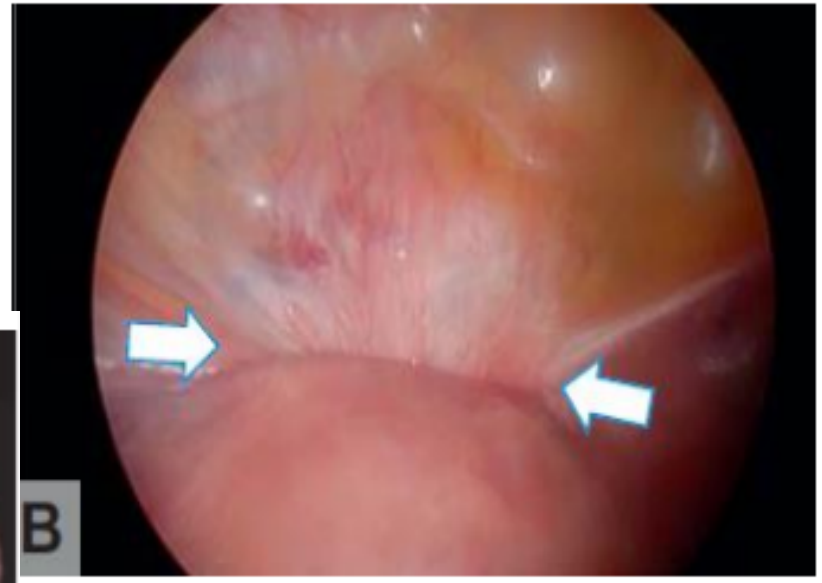
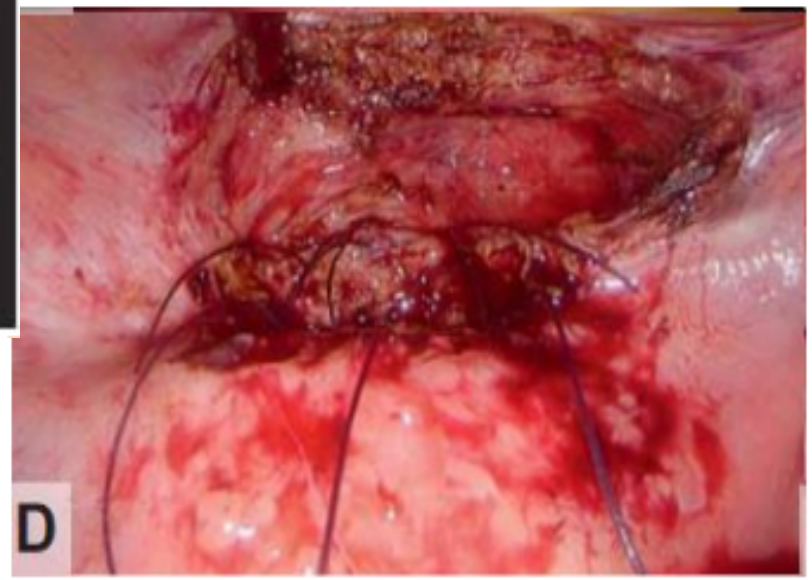
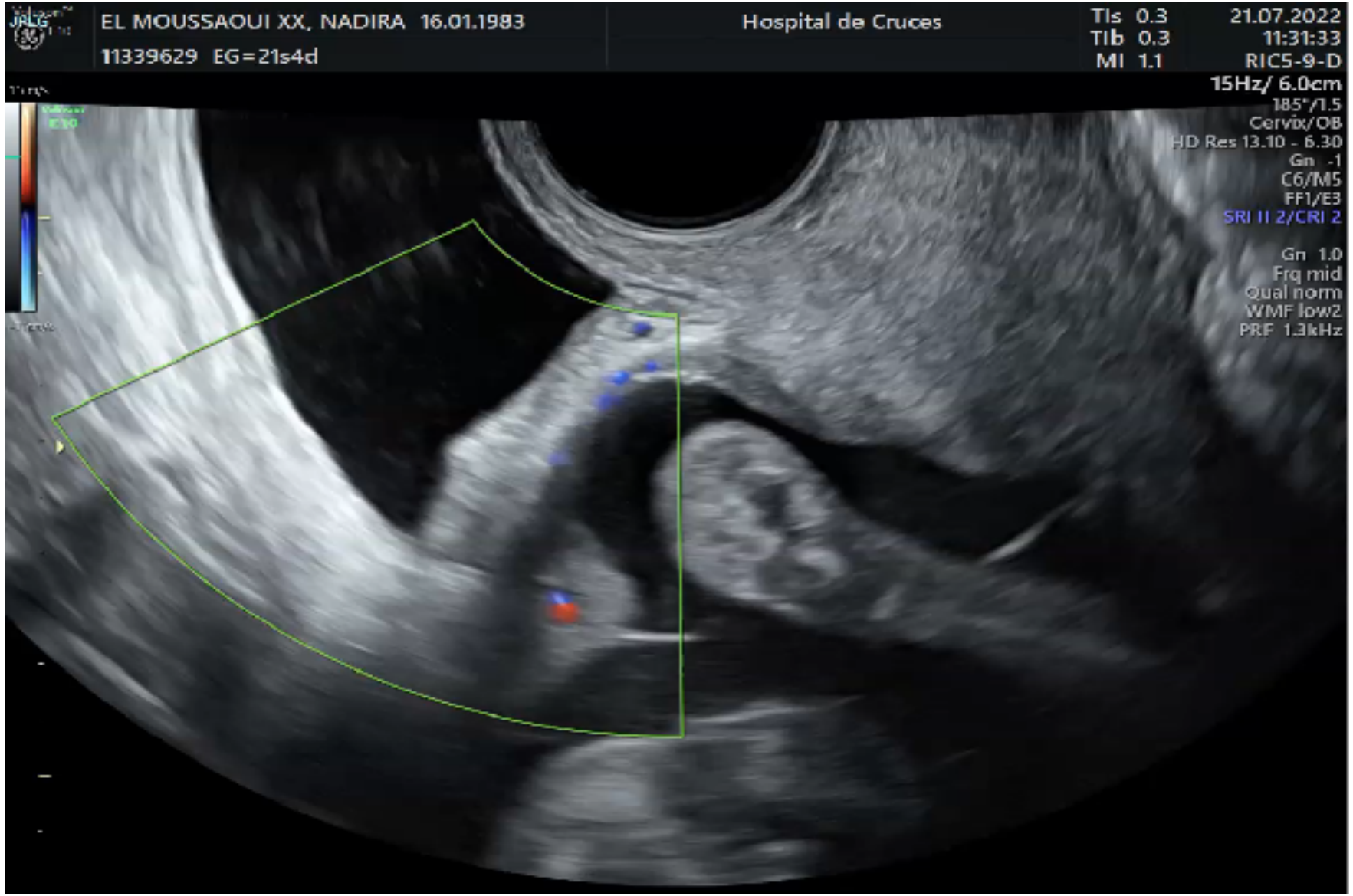
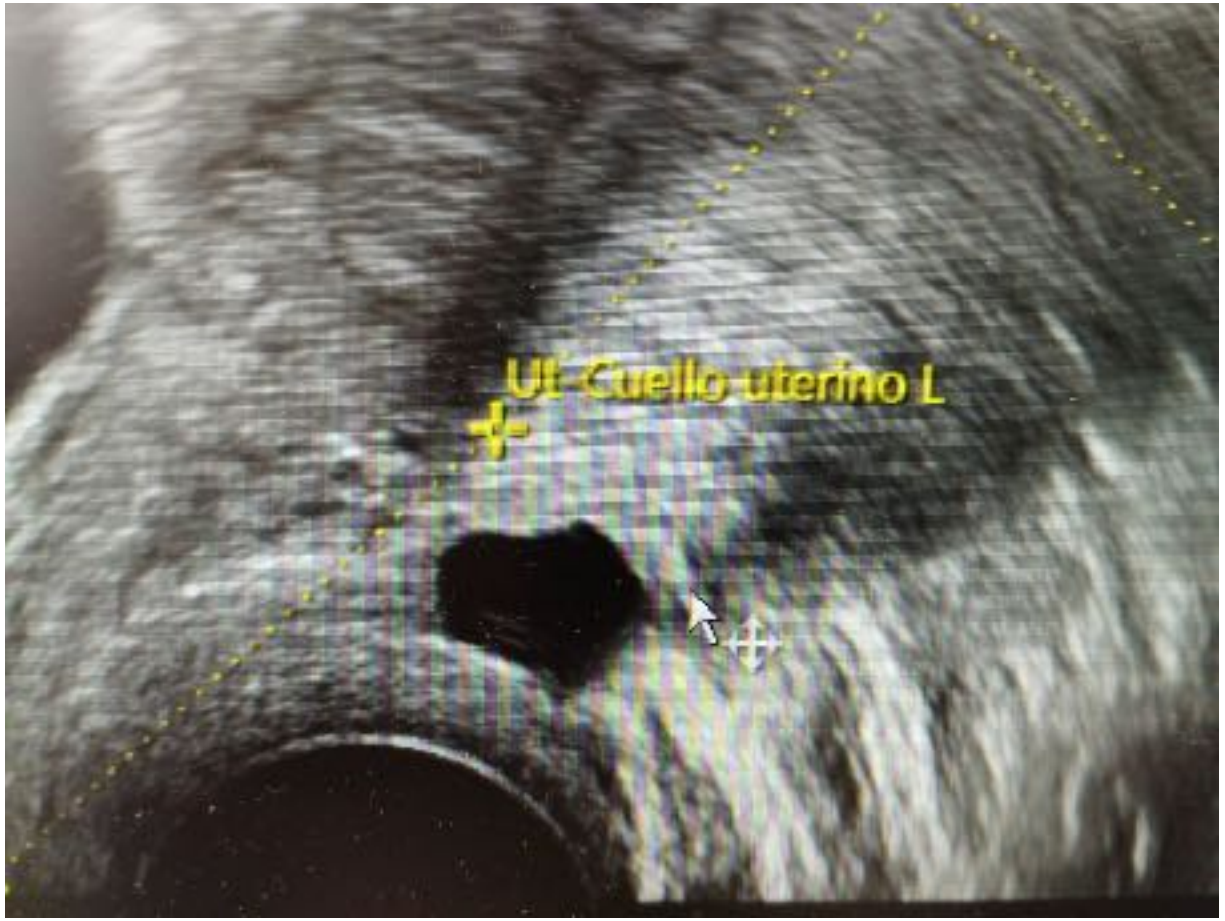

a
b
Istmocele

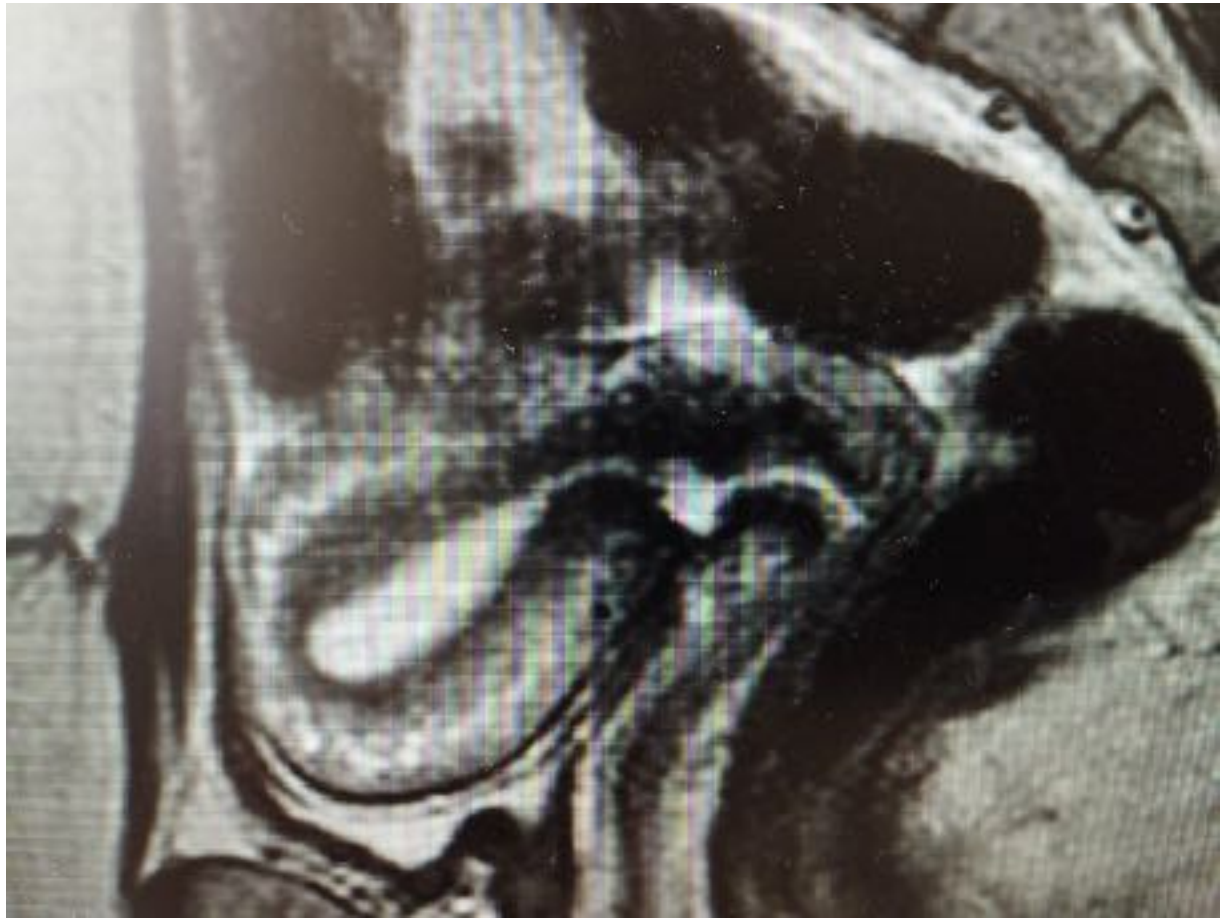

B


D

Dra Ana del Campo, HU Cruces




UI Cuello uterino L



Human Reproduction, Vol.28, No.7 pp. 1943–1952, 2013
Advanced Access publication on May 3, 2013 doi:10.1093/humrep/det130

human reproduction

META-ANALYSIS *Reproductive epidemiology*

Impact of Caesarean section on subsequent fertility: a systematic review and meta-analysis

I. Gurol-Urganci[1,2,*], S. Bou-Antoun[1,†], C.P. Lim[3,†], D.A. Cromwell[1], T.A. Mahmood[2], A. Templeton[2], and J.H. van der Meulen[1]

Espermicida

Efecto sobre moco cervical

Efecto sobre endometrio

ELSEVIER

JMIG
The Journal of Minimally Invasive Gynecology

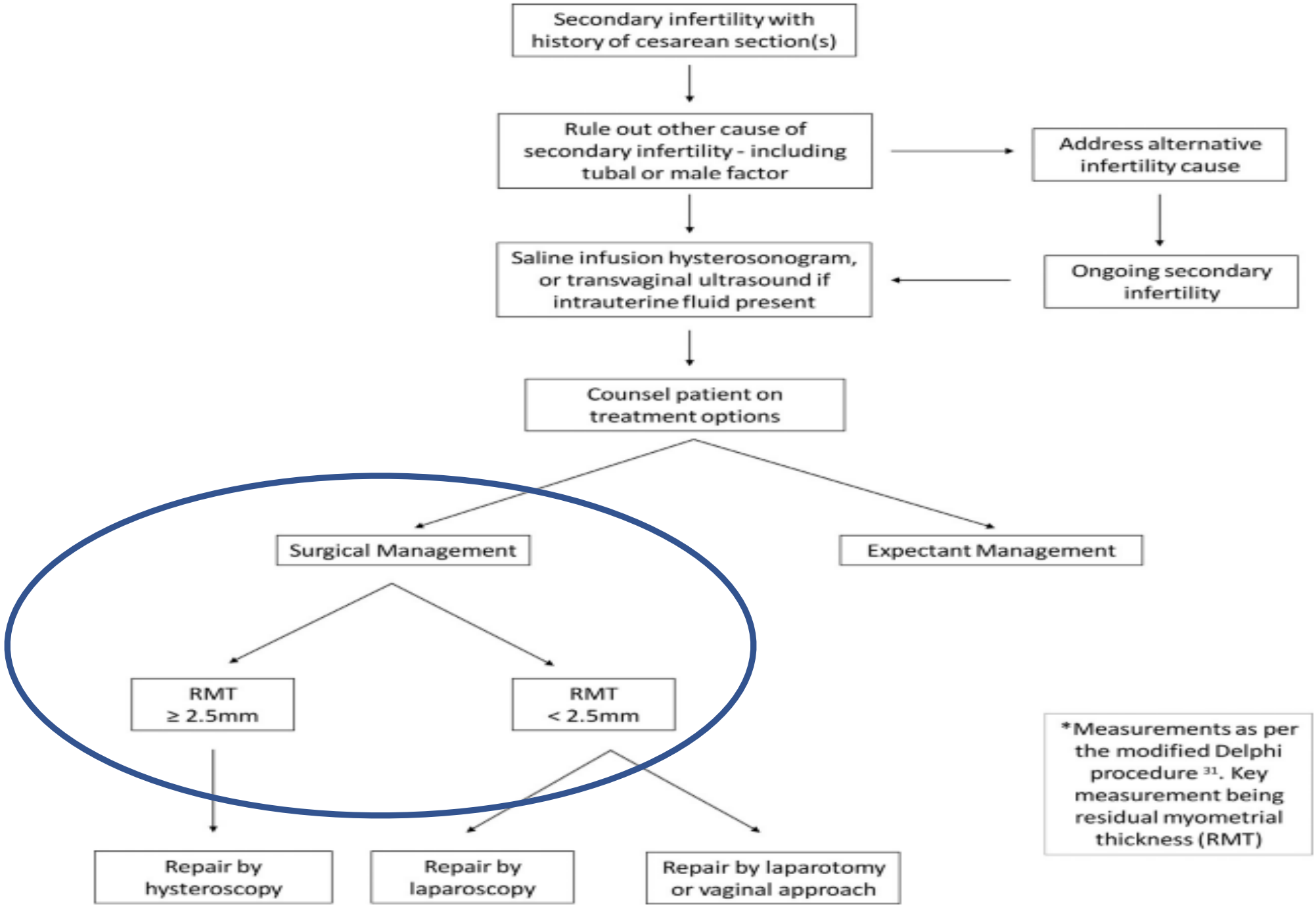
Review Article

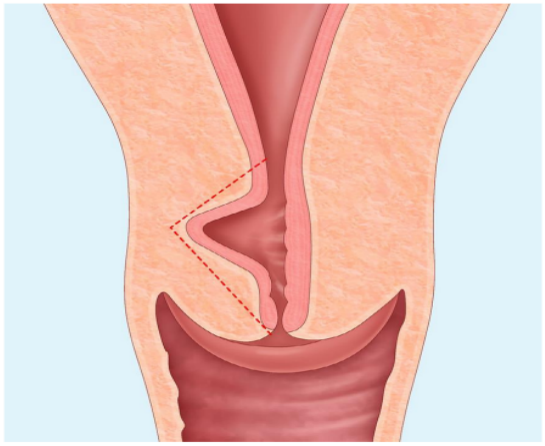
Reproductive Outcomes Following Surgical Management for Isthmoceles: A Systematic Review

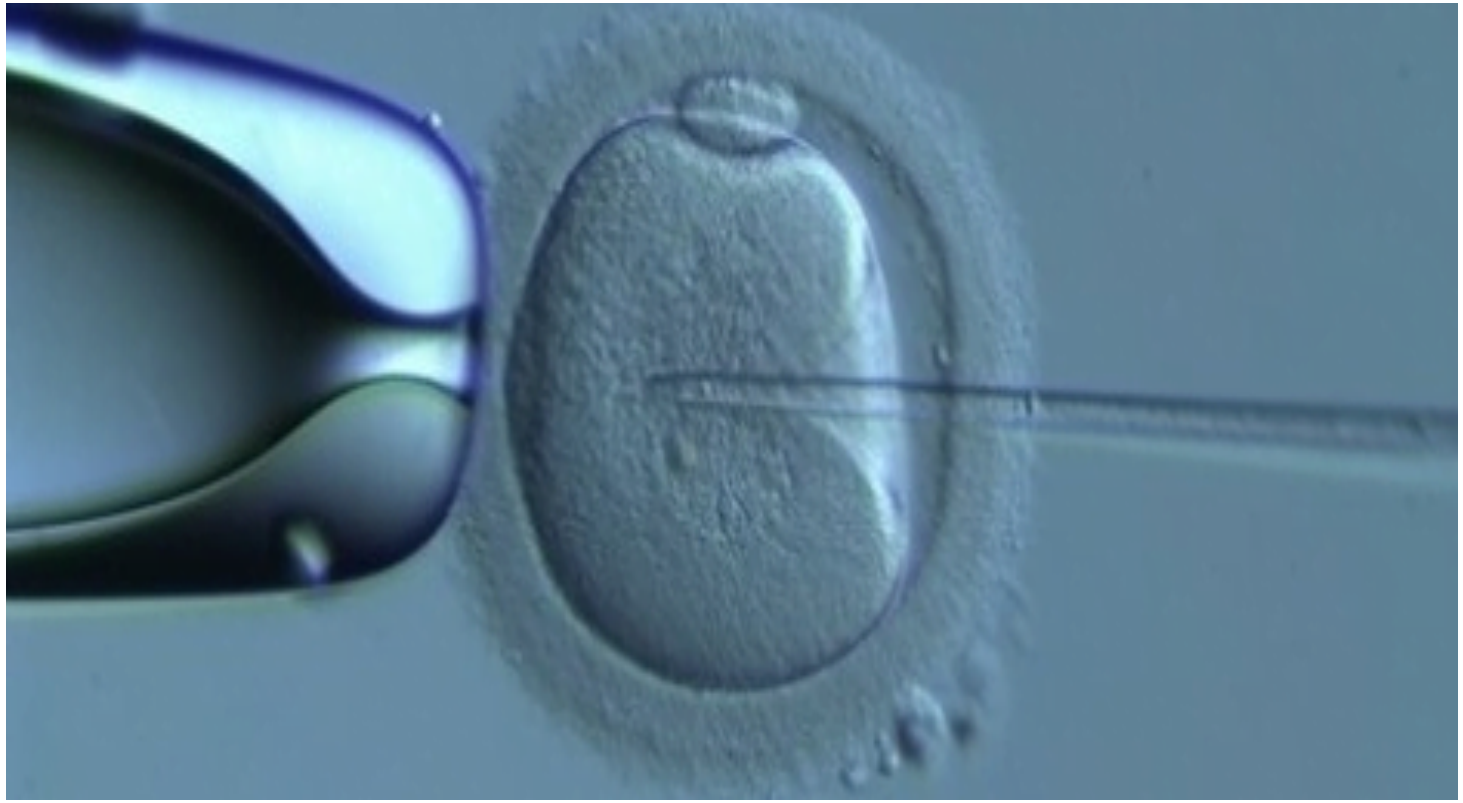
Rahana Harjee, MD, Jaskaran Khinda, BSc, and Mohamed A. Bedaiwy, MD, PhD

From the Department of Obstetrics & Gynaecology (Dr. Harjee), Faculty of Medicine (Mr. Khinda), and Division of Reproductive Endocrinology & Infertility, Department of Obstetrics & Gynaecology (Dr. Bedaiwy), University of British Columbia, Vancouver, British Columbia, Canada

Conclusion: The results of this systematic review suggest that the surgical treatment of an isthmocele, particularly through hysteroscopy, in patients with residual myometrial thickness of at least 2.5 mm, may be effective in treating isthmocele-associated secondary infertility with a relatively low complication rate. Further high-quality studies are needed because of the small sample sizes and observational nature of most available data. Journal of Minimally Invasive Gynecology (2021)


Secondary infertility with history of cesarean section(s)
Rule out other cause of secondary infertility - including tubal or male factor
Address alternative infertility cause
Saline infusion hysterosonogram, or transvaginal ultrasound if intrauterine fluid present
Ongoing secondary infertility
Counsel patient on treatment options
Surgical Management
Expectant Management
RMT ≥ 2.5mm
RMT < 2.5mm
Repair by hysteroscopy
Repair by laparoscopy
Repair by laparotomy or vaginal approach
*Measurements as per the modified Delphi procedure [31]. Key measurement being residual myometrial thickness (RMT)





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- Objetivo: determinar tasa implantación en pacientes con istmocele
- Diseño:
    - · Prospectivo
    - · Variables :
- Principal : efecto del istmocele ecográficamente objetivable en tasa implantación
- Secundarias : variación área istmocele durante estimulación ovárica.

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- Principal : efecto del istmocele ecográficamente objetivable en tasa implantación

  - N **20** (2019-2020) , transferencias embrionarias (16 e SET, 2 transferencias 2 embriones)
  - 2 transferencias diferidas por hidrometra
  - Tasa de implantación NO diferencias significativas

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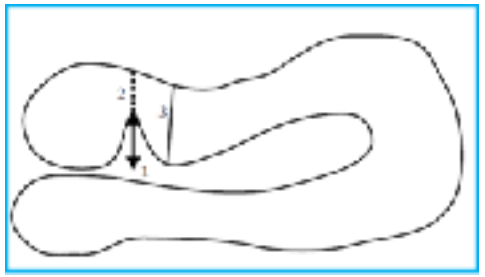
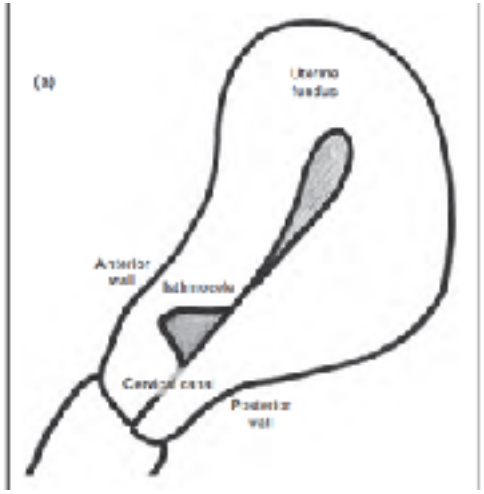
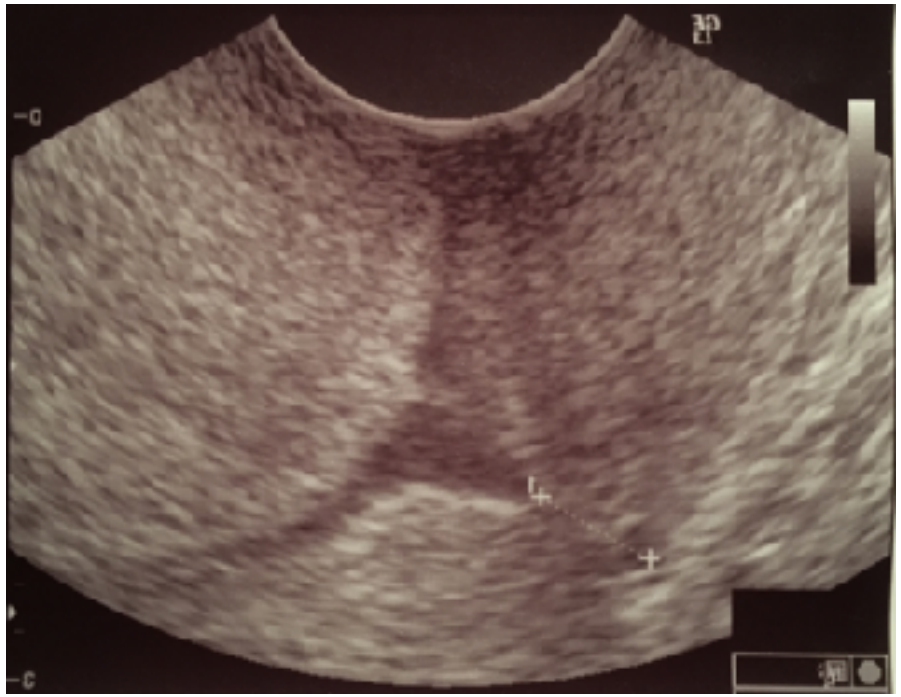
- Secundarias : variación área istmocele durante estimulación ovárica.
  - 2 medidas ecográficas :
    - Primer control estimulación
    - Día *trigger*
  - NO variación significativa







Human Reproduction, Vol.35, No.1, pp. 89–99, 2020
Advance Access Publication on December 30, 2019 doi:10.1093/humrep/dez241

human reproduction

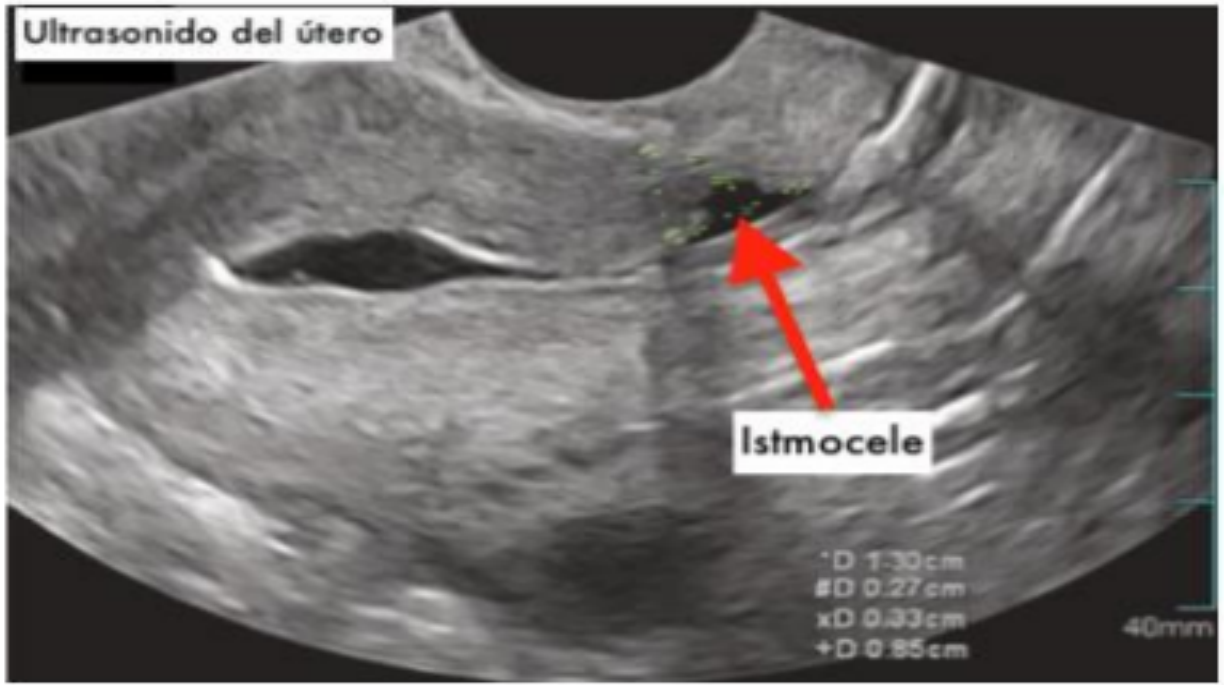
ORIGINAL ARTICLE *Infertility*

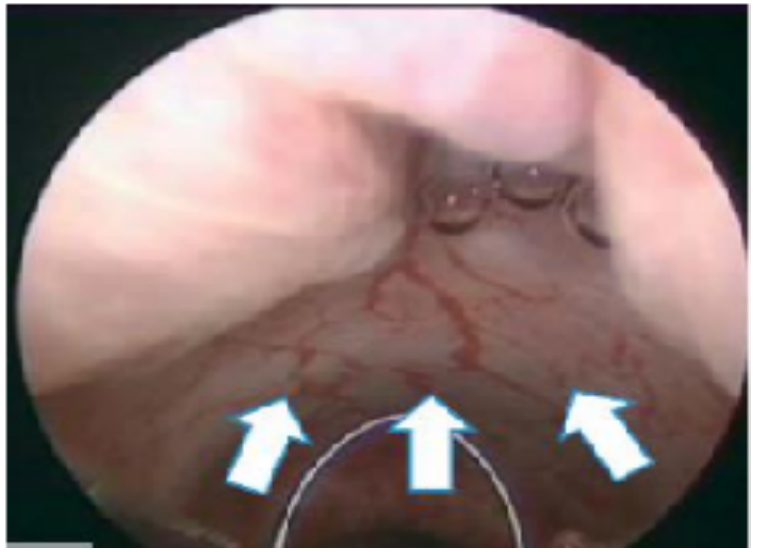
Isthmocele and ovarian stimulation for IVF: considerations for a reproductive medicine specialist

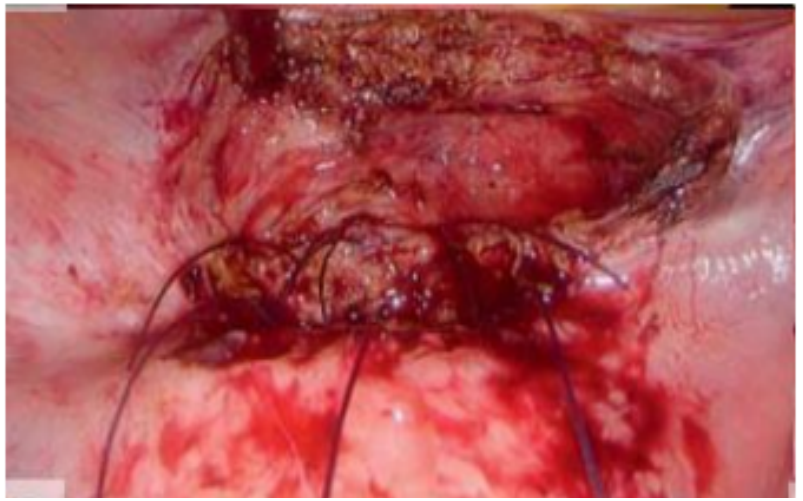
B. Lawrenz[1,2,*], L. Melado[1], N. Garrido[3], C. Coughlan[1], D. Markova[4], and H.M. Fatemi[1]

MAIN RESULTS AND THE ROLE OF CHANCE: Patients with an existing isthmocele after previous CS have a risk of ~40% of developing ultrasonographic visible fluid in the endometrial cavity during the course of ovarian stimulation. Development of ICF was significantly correlated with the depth of the isthmocele on Day 2/3 ($P = 0.038$) and on the day of trigger (−1/−2 days) ($P = 0.049$), circumference of the isthmocele on the day of trigger (−1/−2 days) ($P = 0.040$), distance from the C-scar to the external os ($P = 0.036$), number of children delivered ($P = 0.047$) and number of previous CS ($P = 0.035$). There was a statistically significant increase in the parameters related to the size of the isthmocele during ovarian stimulation. No significant differences in the reproductive outcome (pregnancy rate and rates of biochemical and ectopic pregnancies, miscarriages and ongoing/delivered pregnancies) after FET were found between the patients with and without an isthmocele, when ICF was excluded prior to embryo transfer procedure.

Efecto sobre endometrio







Puntos clave

- Defecto cicatrización
- Divertículo con acumulación material inflamatorio

- Spotting post menstrual , dolor pélvico
- Subfertilidad secundaria

- Tratamiento médico
- Tratamiento quirúrgico : abordaje histeroscópico o laparoscópico
- Punto de corte grosor de miometrio residual 2.5 mm

- No condiciona resultado de FIV-TE salvo casos con hidrometra

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