LAPAROSCOPIC REPAIR OF A SYMPTOMATIC POST CESAREAN ISTHMOCELE:
A VIDEO CASE REPORT

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CAPSULE

Video article describing laparoscopic management of symptomatic post cesarean isthmocele.

ABSTRACT

OBJECTIVE: To describe our technique for laparoscopic management of post cesarean isthmocele.

DESIGN: Surgical video article. Local Institutional Review Board (IRB) approval for the video reproduction has been obtained.

SETTING: University hospital.

PATIENT(S): A 36-year-old patient with a history of two previous cesarean deliveries. She complained of persistent postmenstrual spotting and chronic pelvic pain. At transvaginal ultrasound examination, a cesarean scar defect of 20.0x15.6 mm was identified, with a residual myometrial thickness over of the defect of 2.6 mm.

INTERVENTION: Isthmocele excision and myometrial repair was performed laparoscopically. The first step of the procedure was the cautious mobilization of the bladder from its adhesions with the site of the previous cesarean scar. Subsequently, the isthmocele site was identified with the aid of an intraoperative transrectal ultrasonography. Transrectal ultrasonographic assistance is particularly important when a bulge of the cesarean scar is not laparoscopically visible. Once identified, the isthmocele pouch was incised and its pitchy content drained. Then, the cesarean scar was excised with cold scissors, avoiding cauterization in order to reduce the risk of tissue necrosis. This step is considered completed when the whitish scar tissue of the isthmocele site margins are no longer present and reddish healthy myometrium is visualized. Before suturing the defect, a Hegar dilatator was placed into the cervix with the aim of maintaining the continuity between the cervical canal and the uterine cavity. Then, the myometrial repair was performed with a single layer of interrupted 2-0 Vycril® sutures. We prefer not to add a second layer of sutures in order to limit tissue ischemia.
Finally, the visceral peritoneum defect was closed, with the aim of restoring the physiological uterine anatomy. In this case, multiple peritoneal endometriotic implants were also identified and excised.

MAIN OUTCOME MEASURE AND RESULTS: Operating time was 70 minutes. The post-operative course was uneventful and the patient was discharged on postoperative day 2. At 40-day postoperative follow-up, transvaginal and transabdominal ultrasonography showed complete anatomical repair of the uterine defect. At three-month follow-up, the patient reported resolution of post-menstrual spotting and chronic pelvic pain.

CONCLUSION: Good reproductive outcomes have been reported after hysteroscopic treatment of uterine isthmocele. However, laparoscopy has the advantage over hysteroscopy of allowing thorough repair of the uterine defect, thus restoring a normal myometrial thickness. Therefore, as demonstrated in this case, a laparoscopic approach might be considered the procedure of choice for the repair of a large uterine isthmocele with extreme thinning of the residual myometrium.

KEYWORDS: Isthmocele; Cesarean scar defect; laparoscopy; complication of cesarean; Cesarean section; niche.
SUGGESTED READING


