Study Objective: To report a rare case of heterotopic pregnancy in bilateral salpingectomy patient who successfully treated by laparoscopic surgery.
Design: A case report.
Setting: Noninvasive surgery center in Korea.
Patients: A 33 year-old woman, who was bilateral salpingectomy state, managed by laparoscopic resection of cornual heterotopic pregnancy.
Intervention: Managed by laparoscopic resection of the tubal stump.
Measurements and Main Results: We experienced a case of heterotopic pregnancy in bilateral salpingectomy patient and the ectopic focus was removed by laparoscopic approach successfully.
Conclusion: He possibility of cornual heterotopic pregnancy following bilateral salpingectomy, though very rare, should be considered by every gynecologist. And early detection of heterotopic focus allows noninvasive laparoscopic management.

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Diagnostic Capability of a Laparoscopic Chromopertubation with Monitoring Tubal Perfusion Pressure in Infertile Women

Kishi H, Itoh M, Igarashi S, Imai F, Minegishi T. Obstetrics and Gynecology, Gunma University Hospital, Maebashi, Gunma, Japan

Study Objective: To evaluate the diagnostic capability of a laparoscopic chromopertubation with monitoring tubal perfusion pressure in infertile women.
Design: Retrospective analysis of 184 cases of laparoscopic chromopertubation. The study was conducted from January 2000 to December 2007.
Setting: Gunma University Hospital.
Patients: 184 infertile women who got a laparoscopic chromopertubation at our clinic.
Intervention: All laparoscopic chromopertubation were performed using an automated injector PA203B (Atom, Japan). Dyed saline was injected into the uterine cavity through a balloon HSG catheter or an uterine manipulator at the speed of 500 ml/h. Tubal patency was confirmed with the dye visualized at the fimbria. For patent tubes, tubal perfusion pressure was measured.
Measurements and Main Results: Tubal occlusion rate of patients with endometriosis was not significantly different from that of patients without endometriosis (14% vs. 26%). Average tubal perfusion pressures of those patients were 164 mmHg and 211 mmHg, respectively. Existence of uterine leiomyoma did not alter either occlusion rate (17% vs. 23%) nor average perfusion pressures (203 mmHg vs. 187 mmHg). History of Chlamydia trachomatis infection raised these values significantly. The occlusion rate was raised from 14% to 45%, and the average perfusion pressure was raised from 172 mmHg to 303 mmHg.
Conclusion: Tubal occlusion rate was higher in the patients who had a history of chlamydial infection as compared to the patients who did not. The average tubal perfusion pressure was significantly higher in those patients even they have patent tubes. These results indicate the possibility of the fallopian tube dysfunction in the patients with the history of chlamydial infection even if their tubal patency is confirmed by the normal chromopertubation. We consider that the laparoscopic chromopertubation with monitoring tubal perfusion pressure could be an effective method to find out patients who have patent but dysfunctional fallopian tube.

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Asherman's Syndrome: Women at Risk and Their Post-Treatment Reproductive Outcome

Mackenzie RCF,[1,2] Fefelova E,[1] Nevin A,[1,2] Singh SS,[3,4] Leyland NA.[1,2]
[1]Gynecology, St. Joseph's Health Centre, Toronto, Ontario, Canada; [2]Obstetrics and Gynecology, University of Toronto, Toronto, Ontario, Canada; [3]Gynecology, The Ottawa Hospital, Ottawa, Ontario, Canada; [4]Obstetrics and Gynecology, University of Ottawa, Ottawa, Ontario, Canada

Study Objective: To examine the surgical and obstetrical history of women with Asherman's Syndrome, and to assess their reproductive outcome after hysteroscopic treatment.
Design: A case series of Asherman's syndrome treated by a single advanced hysteroscopist from January 2003 through December 2007.
Setting: Community teaching hospital.
Patients: Forty-two consecutive patients (ages 25–47) with Asherman's syndrome and infertility.
Intervention: Hysteroscopic resection of intrauterine adhesions and seven day post-operative treatment with an intra-uterine stent, doxycycline and estrogen.
Measurements and Main Results: Of the 42 patients, 36 (86%) had a history of at least 1 pregnancy-related dilatation and curettage (mean 1.7), 4 had undergone an abdominal myomectomy, 1 a hysteroscopc myomectomy, and 1 had no identifiable risk factor. Thirty women had stage III-IV Asherman's. Thirty-five women (83%) were available for follow-up telephone interview. Ten (29%) had achieved pregnancy, one woman twice. All had a history of a pregnancy-related dilatation and curettage. All had resumed normal menses post treatment. Seven (70%) had stage III-IV Ashermans, with a pregnancy rate in this group of 23%. The 3 other pregnancies were in women with stage II disease. Nine pregnancies (82%) ended in a live birth, all by cesarean section. Eight (89%) delivered at term and 1 at 35 weeks. Abnormal placentation was diagnosed in 3 women (33%), 1 of these women was treated with embolization, and 1 woman underwent post-partum hysterectomy.
Conclusion: Women who develop Asherman's syndrome often have a history of pregnancy-related dilatation and curettage. Abdominal myomectomy also appears to be a risk factor. Pregnancy is difficult to achieve despite surgical management, however, success is not limited to women with mild forms of Asherman's. Restoration of normal menses appears to be a prerequisite. Once pregnant, spontaneous abortion and preterm delivery do not appear to be increased. Cesarean section is common, 1 indication being abnormal placentation, a complication either of the procedure or the disease itself.

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The Role of Office and Operative Fertiloscopy in the Infertility Diagnostic Work-Up

Pellicano M, Simonelli V, Catena U, Nappi C. Obstetrics and Gynecology, University "Federico II" of Naples, Naples, Italy

Study Objective: To consider the role of office and operative fertiloscopy as a valid alternative to diagnostic laparoscopy in the infertility diagnostic work-up.
Design: Descriptive study.
Setting: University hospital.
Patients: Infertile outpatient patients.
Measurements and Main Results: Fertiloscopy is a minimally invasive procedure, performed in an outpatient setting, under local anaesthesia, which allows the visualization of the posterior pelvis (posterior face of the uterus, ovaries, tubes and intestinal ansae with the rectum), with a technique of introducing an optic in the pouch of Douglas, throught the posterior vaginal fornix, after the creation of a hydroperitoneum. Cromosalpingoscopy, salingoscopy and microsalpingoscopy are also frequently and successfully conbined with the fertiloscopic exploration to complete the infertility work-up. So, patients can avoid not only a real surgical intervention, such as diagnostic laparoscopy, also annoying examinations, as hysterosalpingography. Moreover it is possible to perform operative procedures in office setting, such as adhesiolysis, ovarian drilling, coagulation of endometriotic spots, thanks to Versapoint. The high patient acceptability makes fertiloscopy suitable as an early stage procedure in the management of explained female infertility, expecially if a tuboperitoneal factor is suspected. It may be successfully performed as a repeat or second look procedure for the treatment of endometriotic lesions, in the follow up of tubal surgery, in case of fluid in the pouch of Douglas and in a number of situations contraindicating standard laparoscopy under general anaesthesia. Moreover, fertiloscopy permits to avoid about a 15% of diagnostic laparoscopies. Laparoscopy should be used as a second step in the case of anomalous findings or incomplete evaluation.