

Operative hysteroscopy should be repeated as many times as necessary for the treatment of refractory Asherman syndrome versus is there any alternative therapy worth considering?

Asherman syndrome (AS) is an acquired condition defined by the presence of intrauterine adhesions (IUAs) that result when the bona fide endometrium is replaced by fibrotic tissues. IUAs provoke symptoms such as menstrual abnormalities, pelvic pain, recurrent miscarriage, infertility, abnormal placentation, and attendant psychological distress (1). The destruction of healthy endometrium arises from multiple factors that affect the endometrial stem cell niche and create IUAs. The most common is curettage of the pregnant uterus after delivery of miscarriage.

AS is considered a rare disease, as noted by the European Medicines Agency (2). The gold standard to diagnose and treat AS is hysteroscopy. Notably, because AS classification and treatment guidelines vary across international medical societies and organizations (3), an integrated approach is encouraged by the acronym PRACTICE (PRevention, Anticipation, Comprehensive therapy, Timely surveillance of subsequent pregnancies, Investigation, and Continuing Education) (4).

However, despite significant efforts in conservative management of miscarriages, advancements in hysteroscopic surgical procedures, and the use of novel “anti-adhesive barriers”, the number of diagnosed AS cases has not decreased and approximately 50% of the most severe AS cases remain without a comprehensive cure (4). In this situation, we must ask ourselves whether it is logical to continue to repeat hysteroscopic treatment for refractory AS, expecting different results each time, or whether it is time to think outside of the surgical box, even if beyond our “comfort zone” to attempt to solve an unsolved problem for an important number of our patients.

In this fertile battleground, first we attempt to reach consensus on the definition of AS, the percentage of patients with refractory AS that will remain without cure after actual treatment, and what is the maximum number of hysteroscopies to be attempted to treat moderate to severe AS. Then, our expert panel of reproductive surgeons from the U.S. and Europe, assembled by Keith Isaacson (U.S.), Herve Fernandez (France), and Jacques Donne (Belgium), share their surgical



experience. These experts specifically address key questions regarding their published clinical results, in terms of live birth, that support their practice and whether the progression in hysteroscopic technology and their extensive experience have improved these results. A complementary perspective on this issue is presented by the alternative therapeutic approach panel, assembled by Xavi Santamaria (Spain), James Liu (U.S.) and Lusine Aghajanova (U.S.). Dr Santamaria shares advances in AS therapy from the regenerative medicine field, which aims to treat with cells what cannot be treated with drugs or surgery. James Liu (U.S.) presents the amniograft technique as an adjuvant of hysteroscopic surgery, and Lusine Aghajanova (U.S.) illustrates the pros and cons around platelet-rich plasma therapy. These contributors explain the biological plausibility of their alternative therapy proposal, as well as clinical results published to date.

I hope that the wisdom encapsulated in this fertile battle will serve the readers to form or restructure their opinion about this question. It was Albert Einstein who is reputed to have said, “I have no particular talent. I am merely inquisitive.” Let us know your opinion on the *Fertility and Sterility* Dialog (www.fertsterdialog.com).

Carlos Simon, M.D., Ph.D.
Department of Obstetrics & Gynecology, Valencia University & INCLIVA, Valencia, Spain; Department of Obstetrics & Gynecology, BIDMC Harvard University, Boston, Massachusetts; and Department of Ob/Gyn, Baylor College of Medicine, Houston, Texas

<https://doi.org/10.1016/j.fertnstert.2020.01.021>

You can discuss this article with its authors and other readers at
<https://www.fertsterdialog.com/users/16110-fertility-and-sterility/posts/58472-29679>

REFERENCES

1. Dmowski WP, Greenblatt RB. Asherman's syndrome and risk of placenta accreta. *Obstet Gynecol* 1969;34:288–99.
2. Committee for Orphan Medicinal Products. European Medicines Agency. Public summary of opinion on orphan designation 206895/2017. Available at: https://www.ema.europa.eu/en/documents/orphan-designation/eu/3/17/1862-public-summary-opinion-orphan-designation-autologous-adult-bone-marrow-derived-non-expanded_en.pdf.
3. American Association of Gynecologic Laparascopists (AAGL). Advancing minimally invasive gynecology worldwide practice report: Practice guidelines for management of intrauterine synechiae. *J Minim Invasive Gynecol* 2010; 17:1–7.
4. March CM. Management of Asherman's syndrome. *Reprod Biomed Online* 2011;23:63–76.