Successful Pregnancies After Removal of Intratubal Microinsets

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BACKGROUND: Patients with intratubal microinsert sterilization later may request reversal.

CASE: Each patient underwent mini-laparotomy and removal of intratubal microinsets. One patient underwent unilateral tubotubal anastomosis and unilateral tubouterine implantation through a cornual uterine incision. The other patient underwent bilateral tubouterine implantation through a posterior transfundal uterine incision. The first patient became pregnant 4 months after surgery, had an uncomplicated pregnancy, and underwent an elective cesarean delivery at term. The second patient became pregnant 8 months after surgery and had a pregnancy complicated by unexplained abdominal pain at 34 weeks of gestation that resulted in early cesarean delivery.

CONCLUSION: Proximal tubal occlusion from intratubal microinserts can be corrected surgically and can provide patients an alternative to in vitro fertilization.

DOI: 10.1097/AOG.0b013e3182383959

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mbal microinsert sterilization (Essure, Conception, Inc.) is becoming a prevalent form of female sterilization. Previous sterilization research has revealed that as many as 20% of women will regret their sterilization.1 Women who regret their sterilization and who would like to conceive have two options: in vitro fertilization and sterilization reversal. Successful pregnancies resulting from in vitro fertilization after intratubal microinsert sterilization have been described.2 Based on a literature search of the entire PubMed database up to August 2011 (using the key words “Essure” and “pregnancy”), these are the first two reports of successful pregnancy after surgical outpatient reversal of intratubal microinsert sterilization.

CASES

A 37-year-old woman, gravida 0, desired pregnancy and surgical correction of her intratubal microinsert sterilization. She had undergone intratubal microinsert sterilization 5 years previously, and bilateral tubal occlusion had been confirmed by hysterosalpingogram. Sterilization reversal was performed through a transverse mini-laparotomy incision. Incisions were made into the isthmic section of each tube, and the intratubal microinsert coils were removed. A polypropylene (Prolene, Ethicon, Inc.) stent easily passed into the uterine cavity through the left intramural isthmic section of the tube but not the right. Each tube was estimated to be 9.5 cm in length. Owing to easy passage of the tubal stent within the left fallopian tube, a primary tubotubal anastomosis was performed. A retention suture was placed in the tubal mesosalpinx using absorbable monofilament, and an isthmic–isthmic tubotubal anastomosis was performed with interrupted sutures of nonabsorbable monofilament. A right tubouterine implantation was performed through a cornual uterine incision. The isthmic muscularis of the proximal section of each tubal segment was widened by incising at the 3 and 9 o'clock positions to create an anterior and a posterior tubal flap. Patency of each tube was confirmed by insertion of a polypropylene stent through each tubal segment. The proximal end of each stent then was inserted into the uterine cavity. A double-armed absorbable suture was placed through the anterior tubal flap, and a second double-armed suture was passed through the posterior tubal flap. The proximal portion of the isthmic tubal segment was placed into the uterine cavity adjacent to the mucosal lining. The anterior and posterior tubal flaps were sutured against the uterine mucosa by placing the double-armed suture through the anterior and posterior uterine muscularis, respectively. Each suture was tied against

References


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These two cases demonstrate that tubal occlusion caused by newer methods of hysteroscopic tubal sterilization can be corrected surgically and that natural pregnancy is possible. Patients who come to our center for treatment frequently regret their sterilization procedures and have possible. Patients who come to our center for treatment can be corrected surgically and that natural pregnancy is possible.
Schistosomiasis
An Unusual Finding of the Cervix

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BACKGROUND: Schistosomiasis remains a major threat to women’s health in many resource-poor countries and is being seen with increasing frequency in developed countries among immigrants and tourists who have a history of freshwater exposure in endemic areas.

CASE: A 28-year-old asymptomatic African immigrant presented with an abnormal Pap test result showing rare atypical squamous cells. Colposcopy examination showed pale-yellow, finely granular cervical lesions. Calcified Schistosoma hematobium eggs were identified by histology but were absent in urine and stool specimens. Praziquantel treatment was initiated promptly, avoiding significant morbidity.

CONCLUSION: The differential diagnosis of female genital schistosomiasis should be considered for patients who have a history of residence in or travel to endemic areas, including asymptomatic patients and patients presenting a long time after exposure.

(Obstet Gynecol 2012;119:472–5)
DOI: 10.1097/AOG.0b013e31822da6a4

Schistosomiasis, or bilharziasis, is a neglected tropical disease that affects more than 200 million people worldwide,1 predominantly caused by the trematodes Schistosoma mansoni, Schistosoma japonicum and Schistosoma hematobium. It is the third most socio-economically devastating parasitic disease after malaria and intestinal helminthiasis. Forty million women of childbearing age are infected worldwide.1 Fortunately, these waterborne parasites are not found in the natural environments in the United States because of the lack of suitable snail intermediate hosts. However, with increased numbers of immigrants from and tourists to endemic areas, several female genital schistosomiasis cases have been reported in this country.2–5 Furthermore, the actual number of female genital schistosomiasis cases in the United States potentially could be higher for the following reasons: schistosomiasis is not a reportable disease, female genital schistosomiasis can be asymptomatic for a long time after exposure, and the worm can live for up to 30 years. Here we report a case of cervical schistosomiasis due to S. hematobium in a healthy, asymptomatic African immigrant in New England.

CASE

Five years after immigrating to the United States, a 28-year-old South African woman, gravida 0, presented for colposcopy examination owing to rare atypical squamous cells on Pap test and positive human papillomavirus (HPV) testing by DNA hybrid capture (Qiagen). Gynecologic history was normal, and Pap test and positive human papillomavirus (HPV) testing by DNA hybrid capture (Qiagen) were performed. Histologic examination of the specimens showed multiple calcified, degenerated S. hematobium eggs in a fibrotic stroma and an unremarkable overlying squamous epithelium (Fig. 1A). The S. hematobium eggs were oval-shaped, roughly 150×50 micrometers, exhibiting a characteristic terminal spine (Fig. 1B, arrow). The endocervi-