FOETAL BONES CAUSING SECONDARY INFERTILITY (A Case Report)

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ABSTRACT

Secondary infertility due to retained products of conception in the form of foetal bones is a rare entity. Advanced diagnostic technique like hysteroscopy has helped in the diagnosis. Two such cases are reported to highlight their unusual nature.

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KEYWORDS : Infertility, Foetal Bones, Hysteroscopy.

Introduction

Endometrial ossification is a rare finding. The literature regarding this contains around 50 cases and 80% occur after pregnancy. The common symptoms include menstrual disturbances, pelvic pain and infertility. The most widely accepted theory is that the endometrial ossification represents retained foetal bones following spontaneous, missed, incomplete or therapeutic abortion. We present two cases of secondary infertility with history of antecedent abortion with retained foetal bones in the uterine cavity. The role of hysteroscopy has also been emphasized in the diagnosis and management of these cases.

Case - I

A 28-years-old lady para 1 reported to our hospital on 04 Mar 96 with complaints of inability to conceive since July 1994. Patient gave history of full term normal delivery in 1992 followed by spontaneous abortion at 4 months period of gestation in 1994 which was followed by D & E. She had polymenorrhoea following the abortion with no history of dysmenorrhoea. Her menstrual cycle was 15/20-45 days. Previous cycles were regular. Last menstrual cycle was on 01 Mar 1996. There was no history suggestive of tuberculosis, thyroid disorder or any discharge from the breasts. On general examination she was found to be thin built, normotensive with normal vital parameters. Her secondary sexual development was normal. There was no evidence of hirsutism, thyromegaly or galactorrhoea. Systemic examination revealed no abnormality. There was no palpable mass on abdominal examination. Per vaginally, uterus was anteverted, normal sized with free fornices.

Patient was diagnosed and investigated as a case of secondary infertility. Routine blood and urine analysis were normal. Husband's seminogram was normal. H.S.G revealed filling defects in the uterine cavity and both tubes were patent. She was subjected to diagnostic hysterolaparoscopy. Hysteroscopy revealed evidence of endometritis and foetal bones embedded in the endometrium. Majority of the bones were removed hysteroscopically at the same sitting. Laparoscopy showed normal uterus with few flimsy adhe-

sions in the pouch of Douglas. Fallopian tubes were normal and bilaterally patent. Ovaries were normal. Thereafter she was advised Tab Premarin 0.625mg x 21 days. There was no withdrawal bleeding after first course of medicine and cervix was found to be stenosed. Uterine sound was passed and 10-15ml of altered blood was obtained. A transvaginal sonography (T.V.S) revealed echogenic areas in the endometrium in the region of fundus of the uterus with distal acoustic shadowing which was suggestive of remnant foetal bones. A repeat hysteroscopy was performed and remaining foetal bones were removed. Post-operative period was uneventful and repeat T.V.S did not reveal any echogenic areas. Patient was given Tab. Premarin for 3 months and endometrial growth was found to be normal as revealed by serial T.V.S. Patient now has normal cycles and is undergoing treatment for infertility.

Case - II

A 27-years-old para 1 patient reported to the hospital on 19 July 96 with the complaint of inability to conceive for the past 2 1/2 years. She had one full term delivery by caesarean section 5 years ago for pregnancy induced hypertension with failed induction. Thereafter she had one M.T.P done at 3 months period of gestation. Her menstrual history was suggestive of hypomenorrhoea for 2 months. Her previous cycles were regular. Her last menstrual period was on 15 July 96. She had been investigated for infertility about 1 year ago and the histopathological report of endometrium gave a diagnosis of 'Osseous metaplasia'.

General and systemic examination showed no abnormality. Cervix and vagina was healthy and uterus was normal in size, mid positioned and mobile. Her hemogram and urine examination were normal. Serum T3, T4, and TSH were in the range of normality. Husband's seminogram ruled out male factor. Hysterosalpingography showed filling defects in the uterus with patent tubes. Transvaginal sonography showed evidence suggestive of foetal bones in the endometrial cavity. She underwent laparohysteroscopy on 20 July 96. Findings were suggestive of multiple small foetal bones embedded in the endometrium which were removed at the same sitting. Laparoscopy findings were essentially normal. On 22 July 96 patient was discharged with advise to continue Tab Premarin 0.625 mg T.D.S x 21 days and review thereafter for further follow-up. Repeat TVS and hysteroscopy was done after 2 months and it showed healthy endometrium with no foetal bones or adhesions. Patient conceived spontaneously within 3 months and was deliv-

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ered by caesarean section on 10 August 97.

Discussion

The two cases reported, highlight a rare etiology of secondary infertility i.e, due to retained product of conception in the form of "foetal bones". They also illustrate common symptoms for retained osseous tissue in the uterine cavity i.e, menstrual abnormalities and infertility. On reviewing world literature, it has been found that similar case reports have been documented but being few in number they can be counted on finger tips. In the year 1978, Waxman M and Missouri HF (1) have reported a case of endometrial calcification following spontaneous abortion. In 1991, Melius et al (2) have also reported two cases of prolonged intrauterine retention of foetal bones. Both these cases presented as case of secondary infertility. In this article they have reviewed 17 other similar cases. Presence of foetal bones in the uterine cavity cause infertility. Dawood and Tarrett (3) postulated that these structures act like an intrauterine contraceptive devices thus preventing implantation.

The important feature brought forth by our two cases is the necessity of hysteroscopy for diagnosis of

such intrauterine pathology. With the advent of newer techniques, more cases are being reported and this procedure is very essential to make a correct diagnosis and treat at the same sitting (4). It is quite possible that such cases were being missed earlier due to lack of such facilities. The purpose of reporting these two cases was to bring to light a rare cause of infertility and the role of hysteroscopy in its management.

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