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Case Report

Restoration of Menstruation in Asherman Syndrome with Intrauterine Balloon Placement After Hysteroscopic Adhesiolysis: a Case Report

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ABSTRACT

Introduction: Asherman syndrome (AS) is characterized by intrauterine adhesions resulting from basal endometrial trauma, commonly after curettage, and is an important cause of secondary amenorrhea and infertility.

Case Presentation: A 36-year-old woman presented with secondary amenorrhea following curettage for an incomplete abortion. Hysteroscopy confirmed moderate-to-severe intrauterine adhesions (ASRM score 8) extending from the internal cervical os to the uterine corpus, supported by histopathology showing fibrous stroma and squamous metaplasia. Management included hysteroscopic adhesiolysis, intrauterine balloon catheter placement for 10 days, and sequential hormonal therapy with Cyclo-Progynova, followed by repeat hysteroscopy. Menstruation resumed 15 days after the first procedure. Due to residual adhesions, a second adhesiolysis was performed, followed by additional hormonal cycles. At follow-up, the patient achieved regular menstruation with improved uterine cavity (ASRM score 6). This case highlights that hysteroscopy remains the widely accepted technique for diagnosis and treatment, especially when non-invasive imaging is inconclusive. Moderate-to-severe adhesions often require repeated intervention. The use of an intrauterine balloon as a mechanical barrier, combined with hormonal therapy, supports endometrial regeneration and reduces recurrence risk. Despite fibrotic histopathology, restoration of menstruation suggests preserved regenerative potential of residual basal endometrium

Conclusion: A multimodal approach combining adhesiolysis, intrauterine balloon placement, hormonal therapy, and serial hysteroscopic evaluation was associated with menstrual restoration in this patient with moderate-to-severe AS.

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INTRODUCTION

Asherman syndrome (AS), also referred to as intrauterine adhesions (IUA), is a pathological condition characterized by the formation of fibrous scar tissue within the uterine cavity. It occurs when the basal layer of the endometrium sustains injury, disrupting normal regeneration and replacing functional tissue with avascular fibrous bands. These adhesions may partially or completely obliterate the uterine cavity, leading to menstrual irregularities, infertility, recurrent pregnancy loss, and significant obstetric complications, including placenta previa, placenta accreta spectrum, and postpartum hemorrhage [1]

The reported prevalence of IUA varies considerably depending on the population studied. It is found in approximately 1.5% of women evaluated for infertility, rising to as high as 30% among those with a history of intrauterine

procedures [2,3]. In settings with a high burden of endometrial tuberculosis, prevalence can approach 68%. In Indonesia, specific epidemiological data are limited; however, given the country's high rates of post-abortion curettage and ongoing tuberculosis burden, the true incidence is likely underestimated [2].

The cornerstone of AS treatment is hysteroscopic adhesiolysis. However, recurrence rates of adhesion remain high, particularly in moderate-to-severe cases, underscoring the critical importance of postoperative strategies. These include mechanical barriers such as intrauterine balloon catheters or intrauterine devices (IUDs), adjuvant hormonal therapy with estrogens and progestins, anti-adhesion agents such as hyaluronic acid gel, and serial hysteroscopic follow-up [4].

This report describes the clinical course and management of a 36-year-old woman with secondary amenorrhea attributable to moderate to severe intrauterine adhesions following curettage for incomplete abortion, treated with a stepwise multimodal approach at the Fertility, Endocrinology, and Reproductive (FER) division of Dr. Saiful Anwar General Hospital, Malang, Indonesia.

The novelty of this case lies in the emphasis on menstrual restoration as a clinically meaningful early outcome in moderate to severe Asherman syndrome, achieved through a sequential strategy of hysteroscopic adhesiolysis, intrauterine balloon placement, sequential estrogen-progestin therapy, and serial hysteroscopic re-evaluation. An approach that remains clinically relevant because adhesion recurrence rates after treatment are high and post-operative management strategies are not yet universally standardized [5,6].

CASE PRESENTATION

The presentation of this study adheres to the CARE guidelines. A 36-year-old woman (P1001Ab100, married for 16 years) was referred from a district hospital (RS HVA Tulungrejo, Kediri) to the FER Polyclinic of Dr. Saiful Anwar General Hospital (RSSA), Malang, with a diagnosis of secondary amenorrhea, prior cesarean section, and a history of curettage. The patient reported absence of menstruation since August 2024, immediately following curettage performed for incomplete abortion at 12 weeks of gestation at RS HVA Tulungrejo on August 23, 2024. Prior to this event, she had regular menstrual cycles (28–30-day cycle, lasting 5–7 days, requiring 2–3 pads per day, with dysmenorrhea).

In January 2025, she sought care at the outpatient gynecology clinic of RS HVA Tulungrejo, where a transvaginal ultrasound showed no structural abnormality. She was prescribed Microginon (a combined oral contraceptive pill) for 21 tablets, one tablet daily. In March 2025, she returned with persistent amenorrhea; intrauterine adhesion was clinically suspected, and she was referred to RSSA Malang. Relevant obstetric history included: 1) cesarean section in 2011 at RS Amalia Pare for an asthma indication, with delivery of a live male infant weighing 3,100 g; 2) premature delivery at RS Surya Melati of a 600 g male infant who died at 5 days of age; and 3) the curettage for incomplete abortion in August 2024 as described above. She was not using any contraception.

General and hemodynamic conditions were stable. Gynecological examination revealed no active bleeding or discharge; closed, smooth cervix; uterus anteverted and normal in size; no adnexal masses or tenderness. Uterine sounding depth was 4 cm (markedly reduced from the normal 6-8 cm). Transvaginal ultrasound showed a uterus in anteflexion, measuring 7.31 × 4.06 cm. No intrauterine mass or adnexal pathology identified. The endometrial line appeared thin and poorly defined, consistent with the clinical suspicion of intrauterine adhesions. Prior USG at RS HVA Tulungrejo also showed an anteverted uterus measuring 7.21 × 4.05 cm, with no adnexal lesions; no specific endometrial abnormality was reported.

A complete diagnostic work-up was performed to exclude other causes of amenorrhea. Pregnancy was excluded by a negative urine hCG. Hormonal profile showed normal estradiol (77.59 pg/mL) and normal TSH (1.28 µIU/mL) with elevated prolactin (193.9 ng/mL). FSH and LH were not measured as ovarian failure was not suspected clinically. Free T4 was not assessed, given euthyroid TSH. Ovarian reserve was not formally evaluated (AMH/AFC unavailable in our setting), but the patient's history of regular menstruation

Table 1. Clinical Timeline and Management Summary

Date	Clinical Findings	Assessment	Management / Plan
Aug 2024	Curettage for incomplete abortion (12 wks GA). Onset of secondary amenorrhea immediately post-procedure.	Post-curettage secondary amenorrhea	Observed at referring hospital; Microginon prescribed at first visit (Jan 2025)
Apr 10, 2025	First visit to RSSA FER Polyclinic. TVS: thin endometrial line. Sounding depth: 4 cm. ASRM score calculated at 8 (moderate-severe).	Secondary amenorrhea due to suspected Asherman syndrome + prior CS (2011)	Elective hysteroscopy scheduled (Apr 25, 2025)
Apr 25, 2025	First hysteroscopy: adhesions from internal os to corpus confirmed. Adhesiolysis performed.	Asherman syndrome (moderate-severe, ASRM 8)	Hysteroscopic adhesiolysis + intrauterine balloon catheter placement; Proginova 1 tab daily
May 5, 2025 (Post-op visit)	Intrauterine balloon catheter in situ. PA result: fibrous stroma + squamous metaplasia consistent with AS. ASRM score 8.	Post-hysteroscopic adhesiolysis for AS	Plan catheter removal on May 13, 2025. Continue Proginova; switch to Cyclo-Progynova 3 cycles (21/7 regimen)
May 10, 2025	Patient reports spontaneous menstruation (first episode in 9 months).	Menstrual restoration (functional endometrial recovery)	Clinical milestone achieved; proceed with Cyclo-Progynova as planned
May 15, 2025	TVS: uterus 6.19 × 4.33 cm, EL 4.8 mm (indistinct). No mass. Normal gynecological appearance.	Post-adhesiolysis with menstrual restoration	Cyclo-Progynova cycle 1; plan second hysteroscopy after cycle 3
Jun 12, 2025	Clinically stable. ASRM score 6 on examination. Menstruation is reported regularly.	Post-adhesiolysis, on hormonal therapy	Cyclo-Progynova cycle 2; second hysteroscopy planned
Jul 21-22, 2025	Second hysteroscopy: residual adhesions present (ASRM 6). Second adhesiolysis performed (SAB anesthesia). Sounding depth 6 cm. PA: ecto/endocervical tissue + fibrous stroma + chronic inflammation; AS not excluded.	AS (moderate), post-second adhesiolysis	Cyclo-Progynova 6 cycles (21/7 regimen). Monitor menstrual cycle. Third hysteroscopy planned (Oct 2025)
Mar 16, 2026	Regular monthly menstruation for 5-7 days since November 2025. TVS: uterus 5.69 × 3.91 cm, EL 0.44 cm. Sounding depth 6 cm. ASRM score 6.	Post-adhesiolysis (two procedures), completed hormonal therapy (6 cycles)	Continue monitoring. Cyclo-Progynova 6 more cycles. Evaluate endometrial function. Third hysteroscopy pending.

prior to curettage suggested adequate ovarian function. The chronological clinical course, diagnostic findings, therapeutic interventions, and follow-up outcomes are summarized in Table 1.

The multimodal treatment strategy was selected as follows. Hysteroscopic adhesiolysis was chosen as the primary surgical technique because it provides direct visualization and precise resection of intrauterine adhesions, the standard approach for moderate-to-severe Asherman syndrome. An intrauterine Foley balloon catheter, retained for 10 days, was placed postoperatively to physically separate the denuded endometrial surfaces during the early healing phase, thereby reducing the risk of re-adhesion. Postoperative hormonal therapy was prescribed to stimulate endometrial proliferation and support re-epithelialization, consisting of Proginova (estradiol valerate 2 mg) daily for 1 month, followed by Cyclo-Progynova (estradiol valerate 2 mg/norgestrel 0.5 mg) in a sequential 21-day-on/7-day-off regimen.

The first hysteroscopic adhesiolysis was performed on April 25, 2025, under sedoanalgesia. Intraoperative findings confirmed moderate-to-severe intrauterine adhesions extending from the

internal cervical os to the uterine corpus, with significant narrowing of the uterine cavity. Adhesiolysis was performed using hysteroscopic scissors to systematically release the fibrous bands from the central cavity toward the periphery. Following lysis of adhesions, an intrauterine Foley balloon catheter was placed and inflated to serve as a mechanical barrier, preventing re-apposition of the denuded uterine walls during the early healing phase; the catheter was retained for 10 days. A second hysteroscopic adhesiolysis was performed on July 22, 2025. Intraoperative findings showed residual intrauterine adhesions with an ASRM score of 6 (moderate adhesions), reflecting partial but incomplete resolution following the first procedure. Uterine sounding depth at this visit was recorded at 6 cm, indicating improvement from the initial 4 cm at the first presentation.

Postoperative hormonal therapy was administered in two phases. Phase I followed the first procedure: after hysteroscopy, the patient was prescribed Proginova (estradiol valerate 2 mg) orally, one tablet daily. Following catheter removal on May 13, 2025, therapy was transitioned to Cyclo-Progynova (estradiol valerate 2 mg/norgestrel 0.5 mg) in a sequential regimen of 21 days of active tablets followed by a 7-day tablet-free interval, for a total of 3 cycles. This regimen was designed to stimulate endometrial proliferation, support re-epithelialization of the uterine cavity surface, and reduce the risk of adhesion recurrence. Phase II followed the second procedure: Cyclo-Progynova was prescribed for an extended course of 6 cycles using the same 21-day-on/7-day-off sequential regimen, beginning in late July 2025 and concluding in November 2025. Monthly outpatient follow-up at the FER polyclinic was conducted throughout this period to assess menstrual pattern, endometrial thickness on transvaginal ultrasound, and clinical response.

Follow-up outcomes included histopathological findings and clinical results. The first biopsy on May 5, 2025, showed endometrial tissue with squamous metaplasia and fibrous stroma, consistent with Asherman syndrome, with no evidence of malignancy, tuberculosis, or granulomatous inflammation. The second biopsy on July 23, 2025, revealed ectocervical and endocervical tissue with squamous metaplasia, fibrous stroma, and chronic inflammation, though Asherman syndrome could not be excluded. Regarding clinical outcomes, menstrual restoration was the primary endpoint. The patient reported spontaneous menstruation beginning May 10, 2025, just 15 days after the first hysteroscopic adhesiolysis, representing her first menstrual episode in approximately 9 months since the curettage in August 2024.

At the most recent follow-up on March 16, 2026, key outcomes included: regular monthly menstruation lasting 5-7 days, consistently maintained from November 2025 through March 2026 (more than 4 consecutive months); uterine sounding depth improved from 4 cm at initial presentation to 6 cm; ASRM score progressed to and remained stable at 6 (moderate); endometrial thickness increased from virtually undetectable at baseline to 4.8 mm (May 2025) and 0.44 cm (March 2026); and uterine size normalized to 5.69 × 3.91 cm (March 2026). The patient has not yet attempted conception, and she was advised to undergo fertility counseling and consider a trial of natural conception or assisted reproduction when ready. No adverse events were reported in relation to the intrauterine balloon catheter or hormonal therapy, supporting the safety and tolerability of the treatment approach.

Table 2. ASRM Score Calculation

ASRM Parameter	Pre-op Score	Post-op Score
Extent of cavity involvement	2 (<1/3-2/3)	2 (<1/3-2/3)
Type of adhesions	2 (Filmy and Dense)	2 (Filmy and Dense)
Menstrual pattern	4 (Amenorrhea)	2 (Decreased)
Total ASRM Score	8	6

Note: ASRM (1997) classification system for intrauterine adhesions. Scores are calculated based on three parameters: extent of cavity involvement, type of adhesions, and menstrual pattern. Values in parentheses indicate qualitative descriptions corresponding to the numerical scores. Interpretation: Moderate Asherman syndrome (ASRM score 5-8)

The patient expressed significant emotional relief upon the return of her menstruation after nine months of amenorrhea. She had been deeply worried about her future ability to conceive. With the establishment of regular monthly cycles lasting five to seven days, she reported feeling more hopeful. The patient voluntarily agreed to share her anonymized experience for medical education purposes, hoping to help other women facing the same condition. Written informed consent was obtained from the patient for the publication of this case report and any accompanying images. The patient was informed that her identity would remain anonymous, and she was given the opportunity to review the manuscript prior to submission. A copy of the signed consent form is available from the corresponding author upon request.

DISCUSSION

Asherman syndrome (AS) is defined by avascular myofibrous intrauterine adhesions accompanied by at least one clinical symptom, such as infertility (97.7% of cases, primarily primary 56.5%), menstrual disorders (amenorrhoea with a relative risk 26.19 times higher, hypomenorrhea 40.6%), dysmenorrhea, non-cyclic pelvic pain, recurrent miscarriage, or abnormal placentation. Some cases are asymptomatic or overlap with other conditions, so a high clinical suspicion is required, especially in cases of secondary amenorrhoea following intrauterine procedures [1,7].

The pathogenesis of intrauterine adhesions involves abnormal wound healing after basal endometrial injury, driven by TGF-β1-mediated fibroblast activation and excessive extracellular matrix deposition. Chronic inflammation (TNF-α, IL-1β, IL-6), epithelial-to-mesenchymal transition, deficient autophagy, and ferroptosis perpetuate the fibrotic process. In this patient, histopathological examination confirmed dense fibrous stroma and squamous metaplasia, the latter indicating an advanced chronic fibrotic process associated with a less favorable prognosis for endometrial regeneration [8,9].

For diagnosis and determination of clinical severity, the ASRM classification system provides a numerical score based on the extent of cavity involvement, type of adhesions (filmy vs. dense fibrous), and menstrual pattern. An ASRM score of 8 (extension 2 + type 2 + amenorrhoea 4) indicates moderate-severe disease. Patients in the moderate-severe category have lower rates of menstrual restoration and successful pregnancy and are more likely to require multiple adhesiolysis procedures compared to mild adhesions. In the mentioned case, although the first-line adhesiolysis was successful, residual adhesions were still found during the second hysteroscopy (ASRM 6), necessitating a repeat procedure and further hormonal therapy [1,10]. This case exemplifies that finding: despite successful first-line adhesiolysis, residual adhesions were confirmed at the second hysteroscopy (ASRM 6), necessitating a second procedure and an extended course of hormonal therapy. Changes in the severity of intrauterine adhesions according to the ASRM classification before and after treatment are presented in Table 2.

Hysteroscopic adhesiolysis is widely recognized as the most effective method for treating intrauterine adhesions, enabling direct visualization, precise lysis, and simultaneous tissue sampling. Current recommendations favor hysteroscopic scissors over electrosurgical energy to minimize additional thermal trauma to the residual endometrium [11,12]. In the presented case, the first adhesiolysis successfully opened the uterine cavity sufficiently to restore menstruation (return on May 10, 2025). The second procedure, performed two months later, addressed residual adhesions that had not been fully resolved initially. This sequential, stepwise hysteroscopy approach—rather than attempting complete resolution in a single session- is recommended for moderate-to-severe Asherman syndrome, as it minimizes additional trauma and allows endometrial recovery between procedures [13].

The intrauterine balloon catheter is more commonly used because it acts as a temporary mechanical barrier that keeps the anterior and posterior uterine walls from touching each other during the endometrial healing process post-adhesiolysis, thereby reducing the risk of adhesion recurrence. Additionally, the balloon on the Foley catheter exerts light pressure on the endometrial surface, which helps maintain the shape of the uterine cavity and reduces post-procedure

bleeding. Thus, the main advantage of the balloon lies in its ability to reconstruct the anatomical cavity of the uterus and control early recurrence [14,15]. For patients with extensive adhesions (e.g., from internal os to corpus), the Foley balloon catheter is often selected over IUD because it provides immediate mechanical separation of denuded walls during the critical early healing window, is widely available and cost-effective, and offers more reliable physical separation compared to HA gel alone during the first days post-adhesiolysis [14,15]. The catheter is typically retained for 3-7 days, though longer retention (up to 10 days) may be appropriate for more extensive adhesions when infection risk is carefully monitored [16].

Sequential hormonal therapy with Cyclo-Progynova (estradiol valerate 2 mg/norgestrel 0.5 mg) is used as adjuvant treatment after hysteroscopic adhesiolysis. The regimen follows a 21-day-on/7-day-off schedule, providing estrogen-driven proliferation followed by progesterone-induced secretory transformation to mimic the physiological menstrual cycle and promote organized endometrial regeneration [17]. A prospective randomized study by Yi et al. (2023) reported improved menstruation in 67% of patients and increased endometrial thickness after adhesiolysis with hormonal therapy [17].

However, a randomized trial by Hanstede et al. (2023) found no significant difference in adhesion recurrence or pregnancy outcomes between estrogen-treated and untreated groups when both used IUDs as mechanical barriers, suggesting that mechanical components may play a more dominant role in adhesion prevention [18]. In the presented case, the combination of balloon catheter plus Cyclo-Progynova reflects a multimodal approach: the balloon addresses physical re-apposition risk in the immediate post-operative period, while estrogen supports tissue-level regeneration over a longer timeframe. The return of regular menstruation is consistent with the synergistic benefit of this combination.

Prevention of recurrence of adhesions after adhesiolysis is one of the most clinically challenging aspects of Asherman syndrome (AS) management. Without a post-operative mechanical barrier, the denuded anterior and posterior uterine walls may re-appose during healing, reforming adhesions. Recurrence rates in moderate to severe AS can reach 62.5% without preventive strategies [19]. Three principal mechanical or anti-adhesion methods have been compared in the literature: 1) intrauterine balloon catheters, 2) copper or hormonal IUDs, and 3) hyaluronic acid (HA) gel, each with distinct advantages and limitations [15]. In a prospective randomized controlled trial, the balloon catheter group demonstrated a significantly greater reduction in AFS adhesion score than the IUD group, although ongoing pregnancy rates did not differ significantly [14]. A network meta-analysis ranked anti-adhesion interventions by overall performance, placing balloon-based approaches, particularly when combined with adjuvant agents including HA, above IUD alone in terms of adhesion reduction outcomes [15,20].

The risk of adhesion recurrence after adhesiolysis in Asherman's Syndrome is quite high, especially in severe cases that can reach 62.5% [4,12]. Various preventive strategies have been developed, including hormonal therapy with high-dose estrogen (estradiol valerate 4-8 mg/day) followed by progesterone, which has been shown to support endometrial proliferation and form a more stable cavity [19,21]. Additionally, the use of intrauterine physical barriers such as the Foley balloon catheter, IUD, and hyaluronic acid (HA) gel are the three main approaches; the balloon catheter has been shown to provide a greater reduction in AFS scores compared to the IUD, while recent network meta-analyses indicate that balloon-based combinations with biological adjuvants (including HA) are superior to the single IUD in improving adhesions [14]. New biological therapies such as PRP, dry amniotic membrane grafts, or stem cells with scaffolds have also been reported to be promising for improving endometrial regeneration and increasing clinical pregnancy rates [12,19].

Repeat adhesiolysis in patients with Asherman's syndrome is necessary if intrauterine adhesions (whether thin or dense) are still found during a second-look hysteroscopy performed within less than 1 month post-surgery (ideally 2-4 weeks) [22]. This decision is greatly influenced by the initial severity: in mild cases, recurrence occurs in about 20% of patients, while in severe cases, it reaches 40-62.5% [23]. Patients who wish to

pursue pregnancy, especially those under 35 years of age, still benefit from repeated adhesiolysis (even up to 3-5 procedures) because the pregnancy rate reaches 40% and the live birth rate is 27% in the group with repeated procedures [24,25]. The ultimate goal of repeat adhesiolysis is to restore a normal uterine cavity or at least to make both tubal ostia clearly visible. Early detection through repeat hysteroscopy within the first 4 weeks post-surgery is crucial, and prevention of recurrence is a top priority in the management of Asherman's syndrome [26].

Prognosis after hysteroscopic adhesiolysis in Asherman syndrome is influenced by adhesion grade, extent of cavity involvement, adhesion characteristics, and endometrial regenerative capacity. Patients with mild adhesions generally have better outcomes due to minimal damage to the basal endometrial layer. Restoration of menstrual function is a key indicator of treatment success, as it reflects a patent uterine cavity and physiologically responsive endometrium (March, 2011). Fertility outcomes are also commonly used to measure success, with pregnancy rates after adhesiolysis ranging from 40-60% depending on adhesion severity and cavity reconstruction success. However, pregnancy rates are lower in moderate-to-severe adhesions due to extensive endometrial damage affecting implantation receptivity. Importantly, treatment goals are not always fertility-focused; in some patients, restoring normal menstruation and uterine anatomy is the primary objective. In the presented case, the patient had no desire for future pregnancy, so the main goal was menstrual restoration following secondary amenorrhea post-curettage.

Menstrual restoration served as the primary clinical endpoint in this case, as the patient had no desire for future fertility. It is a valid surrogate marker of functional endometrial recovery, specifically, the capacity of regenerated endometrium to undergo cyclical proliferation, secretory transformation, and organized shedding in response to endogenous hormonal signals [13]. Following hysteroscopic adhesiolysis with intrauterine balloon catheter placement and estrogen-progestin therapy, the patient regained regular menstruation (5-7 days per cycle) beginning May 10, 2025 (15 days post-first adhesiolysis), continuing through March 2026. This durable outcome is notable given histopathological evidence of dense fibrous endometrial replacement, which might have predicted poorer regenerative capacity. The restoration achieved suggests that residual basal endometrial stem/progenitor cells may survive and reconstitute functional endometrium when physical obstruction is removed, and adequate hormonal stimulation is provided. Nevertheless, despite menstrual restoration, the patient still had residual adhesions and a relatively thin endometrium, indicating that full uterine recovery was not achieved.

Recent literature emphasizes that menstrual restoration should be formally tracked as a distinct outcome measure in Asherman syndrome trials, separate from pregnancy rates, as it captures a clinically meaningful dimension of treatment success for patients not attempting conception [13]. Long-term follow-up remains essential to monitor for adhesion recurrence; a third hysteroscopy is planned for October 2025 to further assess cavity stability. Should the patient desire pregnancy in the future, assisted reproductive technologies, including IVF, should be considered based on cavity status, patient age, and other reproductive factors. Patients with prior Asherman syndrome who achieve pregnancy face increased risks of obstetric complications such as placenta previa, placenta accreta, and recurrent miscarriage, necessitating closer obstetric monitoring (March, 2011). As the patient has no immediate fertility plans, actual fertility outcomes cannot yet be definitively evaluated, and treatment success is currently best measured by menstrual restoration and anatomical improvement [27-29].

CONCLUSION

In this patient, the combination of hysteroscopic adhesiolysis, intrauterine balloon placement, and sequential estrogen-progestin therapy (Cyclo-Progynova) was associated with the restoration of menstrual function, despite histopathological evidence of dense fibrous endometrial replacement and squamous metaplasia. Additional key elements included ASRM-based severity classification to guide treatment intensity and a multi-session hysteroscopic strategy with serial follow-up to

manage residual or recurrent adhesions. However, despite menstrual restoration, the patient still had residual adhesions and a relatively thin endometrium. Therefore, full uterine recovery was not achieved in this case.

This report describes our local clinical experience with a structured multimodal protocol for moderate-to-severe Asherman syndrome in a resource-limited setting. The sustained menstrual restoration observed in this patient adds to the growing body of evidence supporting comprehensive post-adhesiolysis management strategies, particularly where adhesion recurrence risk is high.

Limitations of this report include its single-case design, limiting generalizability; incomplete endometrial sampling on the second biopsy (yielding predominantly cervical tissue); and absence of long-term fertility outcome data. A planned third hysteroscopy and extended follow-up will provide further information on the durability of cavity reconstruction and potential for future reproductive planning.

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CONFLICT OF INTEREST

In the interest of transparency, the authors confirm that they have no conflicts of interest pertaining to the publication of this work.

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