Introduction
Asherman’s syndrome may result in miscarriage, restricted fetal growth, placenta praevia, placenta accreta and stillbirth.

Case Reports

Case Report 1
Patient was a 33-year-old Chinese, gravida 1 with a history transcervical resection (TCR) of fibroids and uterine adhesions who presented at 13 weeks. Ultrasound findings are as follows:
(i) 21+5 weeks. The amniotic cavity was compartmented, with the fetus seen in left upper quadrant and no fetal parts in lower compartment (Fig 1 & 2)
(ii) 27 weeks. There was a constriction in the mid amniotic cavity with the fetus in the upper compartment and segments of umbilical cords in the lower compartment;
(iii) 32+6 weeks. Lower compartment measured 10 x 13 x 12 cm. Fetus was still in upper compartment, some segments of cord were in lower compartment. Echogenic bowels were noted.
(iv) 35+7 weeks. Fetal demise was noted.

The patient underwent induction of labour. A foetal breech fetus was delivered vaginally. Placenta was located on upper anterior wall and was morbidly adherent. Manual removal of placenta was not successful. The placenta was left in situ in accordance with patient’s wishes. Ultrasound at 39 days post delivery showed placenta to be attached to left superolateral region of uterus with rich vascularity at the placental bed and some intraplacental flow (Fig 3 & 7). Fortnightly scans (Fig 4,5,6,8 & 9) showed the placenta to have shrunk to 8 x 4 x 6 cm by the second month. She underwent TCR with piecemeal removal of part of the placenta. Complete removal of the placenta was achieved with TCR 6 weeks later.

Case Report 2
Patient was a 37-year-old, gravida 2 para 0 with evacuation for a previous early miscarriage. She presented at 31 weeks for second opinion of probable succenturiate lobe of placenta. Ultrasound findings are as follows:
(i) Amniotic cavity was partially septated with the fetal body in the upper amniotic cavity and the limbs and segments of umbilical cord in the lower cavity;
(ii) Main bulk of placenta was anterior in the upper amniotic cavity, reaching to lower anterior wall. Another lobe of placenta measuring 8.1x3.6x7.0 cm. was located on the lower posterior wall of placenta with both lobes joined by a ridge of tissue measuring 5.9 mm.

The scarred and adhered in Asherman’s syndrome restricts blood supply to a developing fetus. Hence, women with Asherman’s syndrome may have a 40% to 80% chance of miscarriage and a one in four risk of premature birth. In the two case reports, there were two large confluent compartments in the uterus. In Case 1, intrauterine demise was detected with a morbidly adherent placenta. Serial ultrasound with the application of Doppler as well as HDLive Silhouette had provided useful information for clinician to plan the appropriate time to remove the adherent placenta.

Case 1
Fig 1: Measurement of upper compartment
Fig 2: Cords in lower compartment
Fig 3: Post delivery placenta demonstrating placental vessels discretely.
Case 2
Fig 1: Fetal body in upper compartment.
Fig 2: Fetal legs in lower compartment
Fig 3: Partial septum between the two compartments
Fig 4: Measurement of ridge of tissue joining the two placenta.

Discussion and Conclusion
The scarred and adhered in Asherman’s syndrome restricts blood supply to a developing fetus. Hence, women with Asherman’s syndrome may have a 40% to 80% chance of miscarriage and a one in four risk of premature birth. In the two case reports, there were two large confluent compartments in the uterus. In Case 1, intrauterine demise was detected with a morbidly adherent placenta. Serial ultrasound with the application of Doppler as well as HDLive Silhouette had provided useful information for clinician to plan the appropriate time to remove the adherent placenta.

In Case 2, a live fetus was delivered via LSCS. The placenta was bilobed as Doppler studies did not demonstrate any succenturiate lobe. Evaluation of placentation in pregnancies with suspected Asherman’s syndrome is integral to planning antenatal care and delivery.