CASE REPORT

PREGNANCY IN A UTERUS DIDELPHYS DELIVERED BY CESAREAN SECTION

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ABSTRACT

Uterus didelphys represents a uterine malformation where the uterus is present as a paired organ. There is presence of double uterine bodies with two separate cervices, and often a double or septate vagina as well. A number of gestations have been reported occurring in Uterus didelphys. Women with congenital uterine malformation usually have higher incidence of complications during pregnancy and delivery. We report the case in our institute of a pregnancy in the left sided uterine body of a didelphys uterus delivered by cæsarean section.

KEY WORDS: Uterine, Didelphys, OHVIRA syndrome.

INTRODUCTION

Mullerian duct anomalies are congenital anomalies of the female genital tract resulting from non-development or non fusion of the mullerian ducts, or failed resorption of the uterine septum. Duplication of the uterus results from the lack of fusion of the paramesonephric ducts in a local area or throughout their normal line of fusion. In uterus didelphys, individual horns are fully developed; normal in size with two cervices inevitably present . Each hemi uteri is associated with one fallopian tube. Although some patients are clinically asymptomatic, mullerian duct anomalies are associated with primary infertility, haematometra and urinary tract anomalies. Normal pregnancies can occur in patients with müllerian duct anomalies, but obstetric complications such as spontaneous abortion, stillbirth and preterm birth are frequent. A specific association of uterus didelphys, unilateral hematocolpos and ipsilateral renal agenesis has been described.

CASE REPORT

A 28 years old primigravida married for one year presented at 35 weeks and 4 days pregnancy in emergency with complaints of per vaginal leakage of half hour duration with no labour pains. She was a diagnosed case of bicornuate bicollis uterus with two cervices and two vaginas, at 8 weeks gestation on antenatal checkup at our hospital. Ultrasound abdomen and pelvis carried at that time revealed bicorneate uterus with gestational sac in left cornu and retroverted right cornu. Both kidneys were normal in size, ruling out (Obstructed hemivagina and ipsilateral renal anomaly) OHVIRA syndrome. At 22 weeks she developed cervical incompetence, for which a MacDonald's stitch was applied under general anaesthesia. No bleeding and leakage was encountered at that time. She was given injectable antibiotics for three days and discharged with relevant advice. She was regularly followed up subsequently . She developed anemia at 26 weeks for which she was given parenteral iron therapy for three times over three weeks time, which corrected the anemia.

She presented at 36 weeks gestation with complains water leaking from vagina. On examination all her vital signs were normal. Her pulse was 96/min, blood pressure was 110/70 mm of Hg, respiratory rate of 16/min, and she was afebrile. She had edema of her feet . On abdominal examination her fundal height was 36 weeks with oblique lie and breech presentation. There were no palpable contractions. Per speculum examination was done which showed clear liquor draining. MacDonald's stitch knot was seen enclosing the cervix which was removed. She was started on injection ceftriaxone 1 gram intravenous 12 hourly. She was given injection dexamethasone 12 mg intramuscular, two doses 12 hours apart for fetal lung maturity . Fetal cardiac tocography was done which was reactive. Uterine contractions were monitored throughout the night with plan to do caesarian section immediately if labour progresses otherwise she was planned for elective caesarian section in morning. At 7 am palpable contractions started; she was shifted to operation theatre immediately for caesarian section.

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General anesthesia was given. Abdomen opened by pfenensteil incision. Intraoperative findings showed a didelphys uterus with flexed breech in left uterus; right uterus was retroverted in position. Each uterus was attached to one tube and ovary. Both uteri had separate cervices opening into separate vaginas. (Figure - I)

Both the vagina were separated completely. An alive baby girl delivered as flexed breech with APGAR score of 9. Placenta and membrane delivered completely. Uterus was closed with chromic catgut 1, hemostasis was secured and abdominal wall was closed in reversed order. Skin was closed with subcuticular proline stitch; clots were removed from vagina at the end. Per rectally 4 tablets of misoprostol were placed. Her post operative recovery was uneventful with hemoglobin of 10.1 g/dl. She was discharged on third post operative day. Skin stitches were removed on 8th post operative day.

**DISCUSSION**

The true prevalence of uterine anomalies in the population is unknown. It is insufficient to consult the older medical literature because of inconsistent diagnostic techniques used in the earlier studies, and the heterogeneity of the subject populations that were studied. However, a recent study indicated that the prevalence of uterine anomalies varies from 0.1% to 10%. These abnormalities can be diagnosed using a combination of ultrasound, hysteroscopy and/or laparoscopy. While mullerian anomalies can be successfully diagnosed using ultrasound, particularly three-dimensional ultrasound.

The uterus is formed during embryogenesis by the fusion of the two paramesonephric ducts (also called mullerian ducts). The two mullerian ducts normally fuse into a single uterine body. Partial fusion of the ducts gives rise to a bicornuate uterus or septate or subseptate uterus. Complete non fusion of the two ducts gives rise to Didelphys Uteri.

The affected women are most often asymptomatic unless associated with complications like atretic vagina or cervix with resultant hematometrocolpos on one side. Other presentations may be dysmenorrhoea or dyspareunia. A strong association of renal agenesis with uterus didelphys (81%) has also been suggested. The incidence of OHVIRA syndrome is very small and only isolated case reports have been published.

Frank breech is the most frequent abnormal presentation in pregnancy with uterus didelphys. Jones quotes a figure of 40% breech presentations with uterus didelphys. Other complications of pregnancy with uterus didelphys include postpartum hemorrhage, uterine rupture, retained secundines, and superfecundation.

As far as the mode of delivery in patients with uterus didelphys, opinion is divided between vaginal delivery and elective cesarean sections. Vaginal delivery has been accomplished merely by excision of the vaginal septum and awaiting spontaneous labor. Because of the high incidence of abnormal presentations and cervical dystocia, many people prefer to perform a cesarean section.

**CONCLUSION**

Congenital uterine anomalies though uncommon but still they present in clinical practice. Sometimes they present as isolated anomalies and most of time associated with other anomalies such as renal agenesis. Careful work up is required not to miss associated anomalies as they may influence outcome. Although in malformed uterus the chances of complications increase in pregnancy but still a good outcome can be achieved with careful monitoring and regular follow up.
REFERENCES


