

A CASE REPORTS OF MULLERIAN ANOMALIES WITH SUCCESSFUL PREGNANCY OUTCOME

ABSTRACT :- A uterine malformation is the result of an abnormal development of the mullerian duct during embryogenesis. Reproductive outcomes are improved because of availability of diagnostic modalities like TVS, HSG, and laparoscopy. Increased incidences of miscarriage, preterm labor, IUGR, malpresentation, abnormal placentation are mostly common in bicornuate uterus. We here present a case of 25 years G2A1 on admission 36 weeks by LMP 35.5 weeks by USG of 15 weeks with ? bicornuate with IUGR with fetal distress FHS:-80-100BPM. Emergency LSCS was done, intraoperative findings revealed bicornuate uterus with single cervix. Post operative was uneventful.

CONCLUSION:- Proper ante natal management and improved diagnostic modalities, pregnancy with bicornuate uterus managed well can lead to good perinatal outcome. With a history of repeated poor pregnancy outcome surgical metroplasty is worth consideration.

KEYWORDS:- BICORNUATE UTERUS WITH UNICOLLIS, IUGR, FETAL DISTRESS.

INTRODUCTION:-

A uterine malformation is the result of an abnormal development of the mullerian duct during embryogenesis. Uterine malformations are estimated 3% to 5%, as a result of which there is primary infertility, primary amenorrhea, recurrent abortions. 15% to 25% of women with uterine anomalies have problems with fertility and reproduction and increased incidence of miscarriage, poor fetal growth, malpresentations, and abnormal placentation and ectopic pregnancies. Reproductive outcomes can be improved with better treatment and diagnostic modalities i.e trans-vaginal sonography, hysterosalpingography and laparoscopy.

Here we present a case of gravida 2 with 1 abortion with bicornuate uterus with left horn pregnancy resulted in good perinatal outcome.

Pregnancy in rudimentary horn was described by Mauriceau and Vassal in 1669. This type of pregnancy is rare and causes grave consequences for both

mother and fetus. Incidence is 1/100000-1/140000. Pregnancy in rudimentary horn may lead to rupture in 2nd trimester causing life threatening condition to the mother. If pregnancy continues till 3rd trimester it may lead to poor perinatal outcome such as preterm labour, IUGR, low birth weight.

Atonic post-partum haemorrhage is also a commonest complication is 3rd trimester because of abnormal placentation.

Rudimentary horn is also associated with many complications throughout women's reproductive life beginning from menarche when hormonal stimulation may gradually activate the endometrium of the rudimentary horn resulting in to haematometra, endometriosis, infertility.

Bicornuate uterus(26%) is a uterine anomaly where the fusion process of the upper part of the mullerian ducts (Paramesonephric ducts) is altered. As a result, the caudal part of the uterus is normal while the cephalo part is bifurcated. Bicornuate uterus are of 2 types.

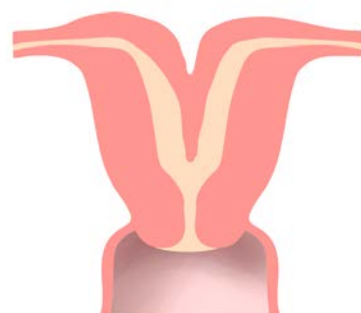
TYPES OF BICORNUATE UTERUS

- Partial :-Bicornuate uterus with unicollis
Two uterine cavities with single cervix

- Complete:-Bicornuate uterus with bicollis

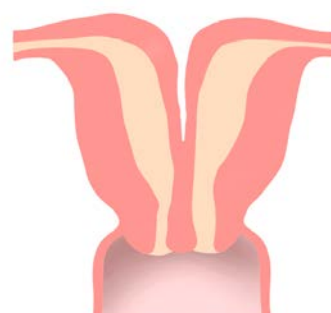
Two uterine cavities with double cervix with or without vaginal septum.

The horn may be equal or one horn may be rudimentary and have no communication with the developed horn.



Bicornuate unicollis

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Reproductive System*



Bicornuate bicollis

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Reproductive System*

Here we present a case with bicornuate uterus with left horn pregnancy which resulted in good perinatal outcome.

CASE:- 23 yrs, Gravida 2 Abortion 1 (G2A1) comes to casualty with a referral letter stating pain in abdomen with oblique lie with fetal distress. Patient was 36 weeks by LMP 35.5 Weeks by USG of 15 weeks with ? bicornuate uterus. On examination per abdomen uterus was 30 weeks in size , FHS were present 80-100BPM regular , Uterus irritable , s/o IUGR. Per vaginal examination ? septum 1 finger loose uneffaced membranes were present cephalic presentation. Injection betamethasone 12mg was given prophylactically. High risk explained to the relatives , Neonatologists informed.

Hence termination of pregnancy was decided by LSCS. During LSCS baby delivered through vertex presentation and did not cry immediately after birth. Baby was handed over to neonatologists intubation was done and baby was shifted to nicu immediately. Intraoperatively patient was incidently found to have bicornuate uterus with left horn pregnancy with single cervix. Male baby of 1.5kg was kept on bubble c pap. Patient was stable after LSCS foley's catheter was removed on day 2. On day 7th baby was on mother side baby weight of 1.7kg. Patient was discharged on day 7

DISCUSSION:EMBRYOLOGY: At six weeks of fetal life both males and females genital tracts have paired paramesonephric (Mullerian) duct and mesonephric (Wolffian) ducts. In females the mesonephric ducts degenerate and by twelve weeks due to lack of testosterone and the paired paramesonephric developed on lateral aspect of mesonephros to reach urogenital sinus at nine weeks and unfused lateral arms of paramesonephric ducts forming fallopian tubes

Paired sinovaginal bulb on posterior aspect of urogenital sinus fuse with lower end of mullerian duct to form vaginal plate. Mullerian ducts undergo internal canalization which results in two lumen divided by midline septum. Reabsorption of septum occurs in caudal to cranial direction. Two mullerian ducts fuse to form single uterine body.

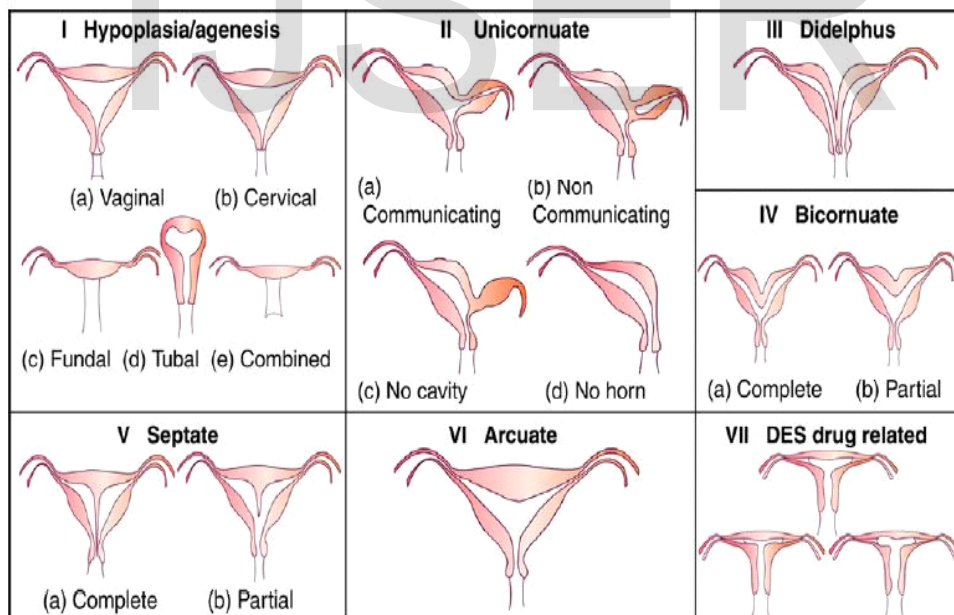


Table 1. ASRM classification of Müllerian anomalies

Classification	Anomaly
Class I (agenesis/hypoplasia)	a. Vaginal b. Cervical c. Fundal d. Tubal e. Combined anomalies
Class II (unicornuate)	a. Communicating b. Noncommunicating c. No cavity d. No horn
Class III (didelphys)	Didelphys
Class IV (bicornuate)	a. Complete b. Partial
Class V (septate)	a. Complete b. Partial
Class VI (Arcuate)	Arcuate
Class VII (DES related)	DES related

ASRM, American Society of Reproductive Medicine; DES, diethylstilbestrol.

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In majority of the cases the presence of an upper genital tract anomaly escapes attention. The incidence of congenital uterine malformation is estimated to be 7-10% of all women and contributing to the problems of infertility , misscarriages , in 25% of women in congenital uterine anomaly. Bicornuate uterus is a congenital uterine anomaly that results from defective lateral fusion of the paramesonephric duct at about 10th week of intrauterine life around the fundus. Mostly the uterine anomaly is an incidental finding during transvaginal sonography, caesarean section, hysteroscopic Dilatation curettage , HSG procedures or during manual removal of placenta.

The detection of congenital uterine anomaly has increased because of physician awareness and improved diagnostic modalities.

CONCLUSION:- Early diagnosis and proper ante natal care is required to manage a pregnancy with bicornuate uterus. If pregnancy managed well can result in good perinatal outcome.

INTRAOPERATIVE IMAGE



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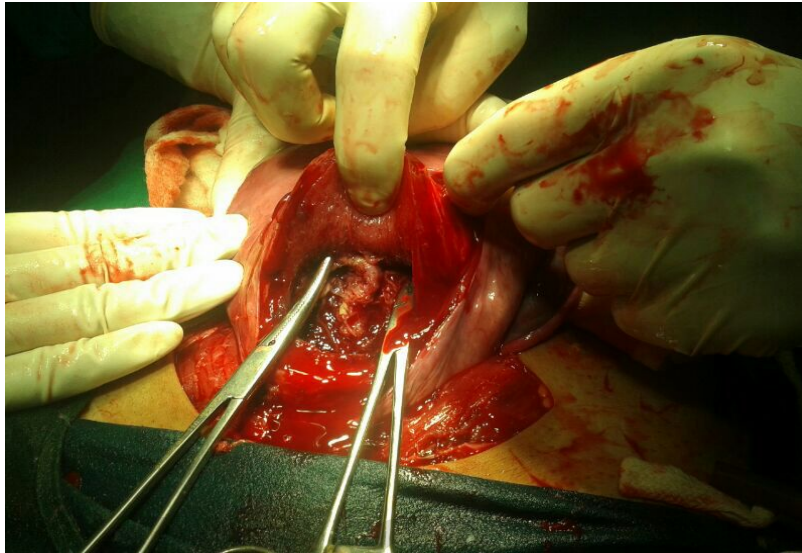
A CASE REPORT 2:-

G2P1L1 with 9 months of amenorrhea with previous LSCS with scar tenderness . Ceaserean section was uneventful intraoperative findings showed ARCUATE uterus.



CASE REPORT 3:-

PRIMIGRAVIDA with 9 months of amenorrhea unregistered uninvestigated with BREECH PRESENTATION in labour. Ceaserean section was uneventful. Intraoperative findings showed SEPTATE uterus.



CASE REPORT 4:-

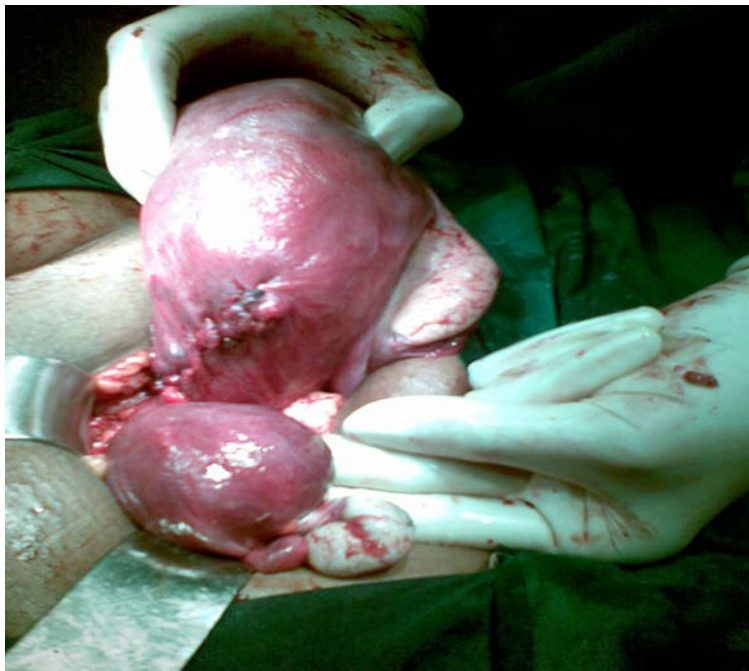
NULLIGRAVIDA with primary infertility with unicornuate uterus on HSG. Patient was put on ovulation induction on IUI. Elective C-section was done in view of breech presentation. Intraoperative findings revealed UNICORNUATE uterus



HYSTEROSALPINGOGRAPHY IMAGE OF UNICORNUATE UTERUS

CASE REPORT 5:-

Primigravida with 9 months of amenorrhea was taken for emergency LSCS in view of precious pregnancy. Intraoperative findings revealed UTERINE DIDELPHYS.



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CASE REPORT 6:-

G3A2 with 8 months of amenorrhea with bad obstetric history came with PPRM with breech presentation in labour. Patient was taken for emergency LSCS. Intraoperative finding revealed uterus bicollis.



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