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PREGNANCY IN DIDELPHYS UTERUS DELIVERED BY CESAREAN SECTION : A CASE REPORT

Gynaecology

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ABSTRACT

Didelphys uterus arises when midline fusion of the mullerian ducts is arrested, either completely or incompletely. It is associated with many obstetrical complications and thus has clinical importance. We present a case of 23yr old primigravida with singleton pregnancy in didelphys uterus and delivered successfully at term by emergency cesarean section.

KEYWORDS

Uterus Didelphys, Mullerian Duct Anomalies, Cesarean Section

INTRODUCTION:

A double uterus is clinically known as uterus didelphys Uterus didelphys is an embryologic deformity resulting from failure of the fusion of the Mullerian ducts between 6 to 22 weeks of embryological development. A longitudinal vaginal septum occurs in 75% of these anomalies. Most sources estimate an incidence of these abnormalities to be from 0.5 to 5.0% in the general population [1-4]. Approx 11% of uterine malformations are didelphys uterus[9]. The most recent and widely used classification systems for different types of Mullerian abnormalities were created by Buttram Jr. and Gibbson(1979) and the American Fertility Society (1988). Most women with uterus didelphys are asymptomatic. Approximately 60% of women with uterus didelphys has successful full term pregnancies[5]. It is important to recognize congenital anomalies of the uterus for 3 reasons: (1) to distinguish them from other unrelated pathology, (2) to investigate other possible complications such as hematometra-colpos, and (3) to evaluate for potential therapeutic intervention for patients who have reproductive dysfunctions[12].

Case report:

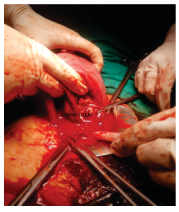
A 23 yrs old primigravida was admitted as a case of right cornual pregnancy at 13 weeks of POG detected accidently on routine USG at her first antenatal visit. Her vitals was stable. On P/A examination uterus corresponding to 14 wks size deviated more towards right was noted. On MRI screening bicornuate bicollis uterus with pregnancy in right cornua corresponding to 11wks 1 day was noted. On PV examination a thick complete longitudinal vaginal septum was noted and on PS examination 2 cervix seen and diagnosis was confirmed for didelphys uterus. Patient and patient's husband were unaware of this fact. Patient had conceived spontaneously within 2 months of marriage. Patient had no H/O dyspareunia. On USG whole abdomen no renal anomalies was noted. Patient was discharged and thereafter followed up in OPD for regular ANC checkup. At 39 weeks of POG patient was re-admitted for safe confinement. Her vitals was stable. Uterus corresponding to term size, relaxed and fetal heart rate was normal. Fetus presented in cephalic presentation and head not engaged. On P/V examination(right) cervix- os was closed and uneffaced. Her term USG report showed fetus with normal biometry, expected weight- 2674gms, AFI- 7.4cm and normal fetal Doppler study. She underwent Emergency LSCS in view of primigravida at term pregnancy with oligohydramnios (AFI- 7.4cm) with uterus didelphys with thick longitudinal vaginal septum. She delivered a single live male baby of 2.5kg in cephalic presentation. The baby was well with APGAR score of 9/10 at 1st minute of birth with no gross visible deformity. Decidual reaction was noted in left uterine cavity. Uterine atonicity was noted which was controlled by uterotonics (inj oxytocin and inj methergin). Bilateral tubes and ovaries were normal. Post operatively 2 ☉ PRBC was transfused. Patient was discharged on post-op day 5 with no complications.

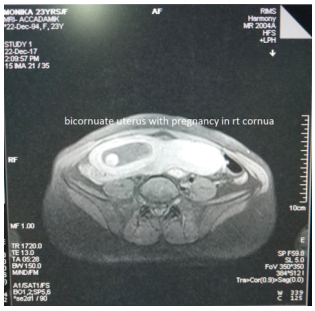
DISCUSSION:

.Didelphys uterus is a very rare mullerian duct anomaly. Septate uterus is the commonest uterine anomaly with incidence of 35%, followed by bicornuate uterus 25%, arcuate uterus 20%, unicornuate uterus 9.6%, didelphys uterus 8.3%, and least of all complete agenesis 3%[4]. Incidence of singleton pregnancy in uterus didelphys is 1 in 3000, incidence of twin gestation is 1 in 5 million and incidence of triplet is 1 in 25 million[7]. In study by Heinonen et al. 9.1% of the patients with uterine anomalies had primary infertility.[8] A retrospective longitudinal study of 3181 patients by Raga et.al demonstrated poor reproductive performance in women with didelphys uterus with high rate of preterm delivery, spontaneous abortion, malpresentations, fetal growth retardation[3]. There is insufficient data on surgical correction (meteroplasty); therefore it is not indicated. Excision of vaginal septum may be required if woman is symptomatic complaining of dyspareunia or pain from hematometrocolpus due to obstruction. A retrospective study on fertility and obstetric outcome done by Zangh et al. in China demonstrated that women with didelphys uterus more frequently required infertility treatment[7]. An unusual capability of didelphys uterus is that, in many cases, intercourse is often possible in both vaginas. Moreover, simultaneous pregnancies in each uterus can occur, albeit rarely. The twins are always dizygotic. Some experts consider each pregnancy a separate entity. This theory is supported by reports in which the second twin was delivered after a long interval, ranging from 3 hours to 5 days to 8 weeks, after delivery of the first twin. Lactation is reported to occur after the birth of the second twin[10]. A didelphys uterus is not an indication for cesarean delivery and thus vaginal delivery should be considered first. When didelphys uterus is diagnosed renal anomalies should also be investigated to rule out Herlyn-Werner-Wunderlich (HWW) syndrome. It is characterized by anomalies of both the müllerian and wolffian ducts, consisting of the following triad: uterus didelphys, obstructed hemivagina and ipsilateral renal agenesis[11].

CONCLUSION:

The didelphys uterus is very rare Mullerian duct anomaly with varying reproductive and gestational outcomes in comparison to other more common abnormalities. Patient with uterus didelphys belong to high risk group and usually diagnosed accidentally and deserve meticulous prenatal care. Serial sonograms necessary to evaluate fetal well being and growth.





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