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BICORNUATE UTERUS WITH FULLTERM PREGNANCY

Sania Tanveer Khattak, Zakia Abid
Department of Gynaecology and Obstetrics
Saidu Medical College/Saidu Teaching Hospital Swat

ABSTRACT:
Congenital anomalies of uterine cavity due to mullerian abnormalities are quite rare. We report a case of full turm pregnancy in a primigravida rhesus negative woman having two almost separate uterine cavities with one cervix. The woman had recurrent episode of intrauterine bleeds and was repeatedly admitted to hospital. She was diagnosed during operation and an alive male baby was delivered. Placenta was morbidly adherent and the horn was excised on leftside.

Key Words:
Bicornuate uterus, congenital anomalies of uterus

INTRODUCTION:

The incidence of congenital malformation of female genital tract is about 0.1-1% in female population[1]. Seventy five percent (75%) women with mullerian abnormality will remain asymptomatic[2]. The remaining 25% will present with various symptoms like acute abdomen, primary amenorrhoea, haematocolpos haematometra, repeated abortions, infertility, ectopic pregnancy, preterm labour and malpresentation[3]. Mullerian abnormalities can occur in isolation or in association with other abnormalities[4]. Diagnosis can usually be made by examination under anaesthesia, ultrasonography, hystrosalpingography, laparoscopy and magnetic resonance imaging[5,6].

We report a case of bicornuate uterus in a primigravida who presented as acute abdomen.

CASE REPORT:

A 25 Years old primigravida with 9 months pregnancy admitted in medical ward with severe pain abdomen, vomiting and was referred to obstetric unit with possible labour pains and bleeding per vaginum. On examination patient was extremely tender on abdominal examination and the lie of foetus could not be made out. On pelvic examination presenting part was above the pelvic brim and bleeding was present. Ultrasound was done, the lie of foetus was transverse and liquor was almost absent. In view of the condition of patient and transverse lie, patient was immediately shifted to operation theater (OT) for caesarean section. Two (2) pints of O negative blood was arranged. On opening the abdomen, the baby was lying in extreamely thinned out congested (blue) uterus. Baby was delivered with Apgar score of 2/10 and then it was found that placenta was morbidly adherent to the uterine wall and another small uterus was found on the right side. It was left bicornuate horn pregnancy and the horn was partially ruptured. Resection of bicornuate horn done and haemostasis was secured. The cervix was single, the tube and ovary of left side were conserved. Right side ovary, fallopian tube and uterus were normal. Uterus was communicating with cervix. Baby was resuscitated, peritoneal toilet was done and abdomen was closed in layers. Three (3) pints of O negative blood was transfused. Patient had uneventful post operative period. Inj Anti Rh was given and she was discharged from hospital with alive, healthy male baby on 5th post operative day.

DISCUSSION:

Mullerian anomaly is rare, commonly associated with infertility, abortion, ectopic pregnancy, preterm labour, acute abdomen due to ruptured horn, abruption and intra uterine bleeding. In bicornuate uterus with single cervix usually rupture of the horn occur in early 2nd trimester[7]. Pregnancy in such a uterus causes various complications, which increases the incidence of caesarian section [8]. In our case it was found out when a primigravida with transverse lie had caesarean section. Although she had no history of abortions and this was her first pregnancy. A rare occurrence of a chronic abdominal pregnancy secondary to a ruptured bicornuate uterus may

Occur[9]. Conservation of uterus was important, as she was primigravida and a healthy out come of an alive male baby was a rare occurrence in our case.

CONCLUSION:

Bicornuate uterus is a rare congenital anomaly of uterus. It may present as a variety of conditions and management varies from case to case. In acute emergency situation, resection of one horn is life saving and it preserves the fertility of the women. Close follow up of case is mandatory.

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Address for Correspondence
Dr. Sania Tanveer Khattak,
Officers Colony Gulkada,
Saidu Sharif, Swat