A CASE OF UTERUS BICORNIS UNICOLLIS WITH ONE RUDIMENTARY HORN MISTAKEN FOR AN OVARIAN TUMOUR

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Congenital malformations of the uterus are interesting curiosities but do not generally give rise to errors in diagnosis, provided a careful history has been taken and a thorough examination performed. This includes an inspection of the vagina and cervix with the aid of a speculum. Sometimes the help of hysterosalpingography may be required.

The following malformations involving the uterus are described. All these are the result of varying degree of faults in the fusion of the Mullerian ducts.

1. Uterus subseptus unicollis.
2. Uterus septus duplex, double vagina.
3. Uterus arcuatus.
4. Uterus bicornis unicollis.
5. Uterus bicornis subseptus.
6. Uterus bicornis septus.
7. Uterus bicornis supra simplex.
8. Partial gynatresia.
9. Uterus bicornis duplex, double vagina.
10. Uterus didelphys, double vagina.
11. Uterus septus duplex.
12. *Uterus bicornis unicollis, one rudimentary horn.*
13. Uterus didelphys, two rudimentary horns: gynatresia.
14. Uterus unicornis.

The diagrams depicting these malformations may be found in standard text books on this subject.

This particular patient whose case notes are presented, had a curious malformation, uterus bicornis with a rudimentary torn which formed a haematometra, which was erroneously diagnosed as an ovarian tumour.

A 19 year old Hindu woman, of average build, a low hirsuite forehead, suffering from advanced gingivitis of the gums, angular stomatitis of the mouth, and fungus infection of the finger nails reported at the outpatients on the 8th January 1955 complaining of abdominal pain. She had been married for five years. She had aborted at the 28th week, 1½ months ago, but she got over this unfortunate event within a few days. Her periods had started soon after that and she completed her last period ten days ago.

The abdominal pain, of which she complained, began like a strain in the right loin a week before her arrival at the hospital. It soon localized itself to the right side of the lower part of her abdomen. The pain varied in severity. She had no nausea or

vomiting. She did not complain of any particular gynaecological symptoms such as dysmenorrhoea, dyspareunia or vaginal bleeding. She had no bladder or bowel symptoms. There was no abnormality discovered on general examination or on abdominal examination. On vaginal examination no congenital malformations were noted. The uterus was found to be slightly bulky, but otherwise normal, retroverted, and deflected towards the left side. The single cervix with its single external os was found to be healthy and the cervical canal was closed. There was nothing abnormal in the left fornix, but the presence of a firm, smooth, spherical, mobile, tumour was noted on the right of the uterus. The tumour was about 5 cms. in diameter and was on the right side of and separate from the womb. Its position and consistency led one to conclude that this was an adnexal swelling.

Adnexal swellings are usually one of three things. They may be inflammatory, neoplastic (tumours of the ovary, fallopian tube or pelvic endometriosis) or the result of ectopic pregnancy. The tumour was discrete, spherical, clearly outlined and not at all tender, all of which seemed to rule out the probability of an inflammatory mass. The patient clearly recollected having had an abortion at the 28th week and passing the contents of the uterus including a foetus. However one should consider the possibility of a subsequent gestation which had chosen an aberrant site in the right tube. She had a perfectly normal period ten days ago, but that does not exclude vaginal bleeding which may occur in tubal pregnancy. The swelling in the right fornix was not tender nor pulsatile. From the physical signs which were elicited the tumour seemed most likely to be neoplastic in nature — probably a tense benign cystic tumour of the ovary. This was the conclusion reached by all who examined the patient.

After suitable preoperative preparation a laparotomy was performed on 11th January and the true state of affairs in the pelvis came to light (Fig. 1.). The normal well-involuted uterus was seen deflected towards the left side. There was a round swelling on the right side of the uterus and separate from it. It was a smooth spherical tumour, the right tube springing from it. Both ovaries were normal. A needle was inserted into the tumour and dark brownish coloured blood was aspirated showing a haematometra to be present. The spherical malformation, forming haematometra, was excised and the defect suitably recovered by apposition of peritoneum. The right ovary was not interfered with. The abdomen was closed in layers and the patient made an uneventful recovery. The tumour when cut across showed a muscular wall. Just like a normal uterus it was lined by velvety endometrium. The lumen contained about 2 ozs. of dark brown blood (Fig. 2).

Summary.

An unusual malformation of the uterus which was mistaken for an ovarian tumour is described. The true state of affairs could not have been diagnosed except by laparotomy. One should always bear in mind congenital malformations of

the genital organs in gynaecological diagnosis.

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References

Masani K. M.: Textbook of Gynaecology, 1954.

Stander H. J.: Textbook of Obstetrics, 1945

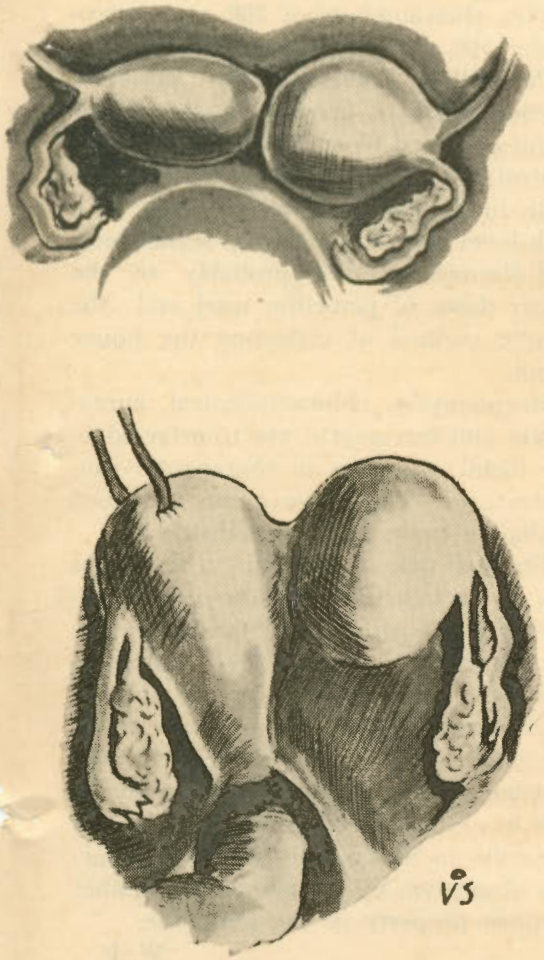

Fig. 1
Fingdings at Laparotomy.

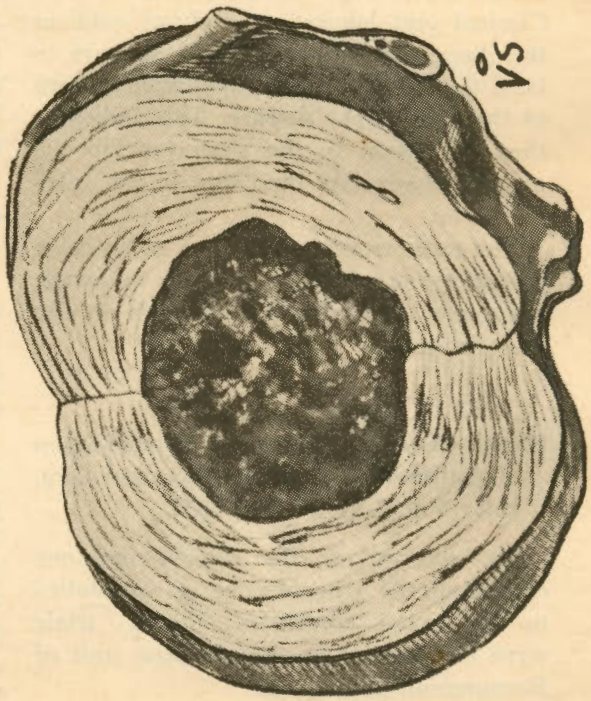

Fig. 2
Accessory cornua opened out to show haematometra.