

PREGNANCY IN A RUDIMENTARY UTERINE HORN

(With an interesting Case Report)

by

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Mouriceau and Vassal, in 1669, first described pregnancy in a rudimentary horn. Kehrer, in 1900, collected 84 cases from the literature. In 1911, Beckmann found 146 cases. Since 1911, only 9 more cases have been added according to Mulsow (1945). Robinson reported a case in 1946, in which the gravid horn ruptured at 38th week and the child was recovered by operation. This patient had recurrent attacks of abdominal colic. Werth collected 100 cases and reported that rupture occurred in 45, about the fourth and fifth month being the usual time for rupture. Douglas Latto and Richard Norman collected 40 cases and added one case of their own. According to the latter, well over 200 cases had been described until October 1950, when they published their paper. Chalmers commented on their case.

Pregnancy in a rudimentary horn can not be delivered *via-naturalem*. In this it differs from cornual pregnancy, with which it is often confused. Clinically, it presents as and is usually diagnosed as an extra-uterine pregnancy, the exact diagnosis being made at laparotomy. However, Targett and Bland-Sutton diagnosed

the condition before operation in a few published case-reports. The gravid horn can be appreciated as separate from the uterus in the early months, but, later when the gravid horn increases in size it may be mistaken for the pregnant uterus and the non-gravid normal horn mistaken for a pedunculated fibroid or an ovarian tumour. At operation, the key to the diagnosis is the position of the round ligament. The round ligament joins the outer side of the gestation sac in cases of rudimentary horn, whereas in the cases of tubal pregnancy the round ligament would lie on the inner side (medial) of the enlarged tube.

The rudimentary horn is not usually found to communicate with the uterine cavity proper, it being postulated that fertilization occurs by migration of the sperm from the opposite side. However, Chalmers, Latto and Norman are of the opinion that the part of the rudimentary horn attached to the other horn is canalized. They have produced hysterosalpingographic and operative evidence to support their view. According to the latter the rudimentary horn is not occluded until after pregnancy in most cases.

The course of pregnancy in a rudimentary horn is variable and depends upon the development of this horn. In a large proportion of cases rupture

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occurs because of the poorly developed muscular and mucous coats, the clinical features of rupture being — recurrent attacks of abdominal pain, tenderness, fainting, haemorrhage, vaginal discharge, and sometimes expulsion of decidua from the normal uterine horn. Less commonly, the rupture and collapse occur suddenly without any premonitory symptoms. The condition may be mistaken for ectopic pregnancy, ovarian cyst with torsion of pedicle, fibromyoma undergoing degeneration, appendicitis, angular pregnancy.

The treatment is the operative removal of the gravid horn. Adhesions between the gravid horn and the surrounding parts may bleed profusely when separated. These adhesions generally result from leakage from the wall injured by the destructive action of the chorionic villi. In many cases normal pregnancy has occurred in the remaining horn.

Case History

Patient, No. 2177 Mrs. R. K., nullipara 19, was admitted to Medical College Hospital on 16-3-63 with the complaints of:

A mass in lower abdomen for 4 years, appearing after a period of amenorrhoea lasting 7 months.

On careful questioning, the patient stated that she felt foetal movements after a 5 month period of amenorrhoea in July 1958. In September 1958, she developed sudden acute pain in abdomen with vaginal leaking but definitely did not faint. The leaking lasted 15 days. The patient, after this episode, did not feel any foetal movements and there was a diminution of abdominal size. She was treated locally, but dull vague pain in abdomen persisted. However, she re-started regular though scanty periods.

In June 1962, patient again had a bleeding episode coming after an amenorrhoea of 3 months. She also passed a fleshy mass,

per-vaginam. The bleeding stopped after this episode and she continued with regular scanty periods. The dull abdominal pain and fullness in lower abdomen persisted, however.

Personal History:

Married 6 years back. Menarche at 12½ years, cycle 4-5/28 regular. After September 1958 the cycle is 2-3/28, painless, scanty flow; last period 5 days back.

On Examination:

Pulse 72 p.m., blood pressure 110/74 mm. Hg., haemoglobin 10 Gm.%, red blood cells 3.2 million/cmm., total white blood cells 8600/cmm. Differential count, polys. 72%, lymphos 26%, mono 10%, eosinophils 1%.

Lungs and heart clinically normal. Examination of abdomen, revealed a mass filling the lower abdomen and arising from pelvis; it extended up to half an inch below the umbilicus. It was an irregular mass, firm in consistency and at places even stony hard. It was slightly mobile from side to side, non-tender and dull on percussion.

Vaginal Examination:

Revealed a closed os, cervix in mid-position, firm. There was a firm irregular mass, felt through all the fornices, and appearing to be connected with the uterus which was not felt as a separate entity. Non-tender, only slightly mobile. She was clinically diagnosed as a case of multiple uterine fibroids.

At laparotomy, omentum and small intestines were found adherent to the underlying mass and had to be carefully separated. The mass was identified as arising from a



Fig. 1
X-ray photograph of the specimen.

rudimentary uterine horn. The round ligament was attached on its outer aspect. The mass was excised and the wound in the uterus closed in 3 layers.

Grossly, the mass was a gestational sac in which lay, a dead, mummified foetus of about 6 months. There was another sac 4" x 4" attached to the post surface of the uterus containing two long bones (fibula) which were missing in the foetus.

The ipsilateral ovary was hypertrophied. No evidence of placenta or the umbilical cord was found. Post-operative course was uneventful and she was discharged cured.

Comments

This patient presented with a firm mass in the lower abdomen and dull pain, duration 4 years. She had a pregnancy in a rudimentary uterine horn about 4 years back. This foetus

died inside the gestational sac and was retained there for about 4 years. In the meantime, she had regular periods and even a pregnancy in the normal uterine horn, which terminated at the third month.

It appears that ovulation and normal menstruation is possible in the presence of a retained dead foetus in a rudimentary horn.

References

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