TERM PREGNANCY IN A UNICORNUATE UTERUS

(A Case Report)

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Abnormalities in the development or fusion of one or both mullerian ducts may result in various degrees of malformations varying from total absence of uterus to its complete duplication, and may sometimes be of obstetric significance. Unicornuate uterus per se is a rare congenital anomaly and a term pregnancy in such a malformed uterus is still rarer. It is further interesting to note that such an abnormality may escape the notice of an obstetrician if labour happens to be absolutely normal.

Case history

A primipara was under treatment from the beginning of her pregnancy. She had 3 attacks of threatened abortion in the 2nd trimester which were controlled by rest, sedatives, thyroid in small doses and progesterone. On 24th September she was admitted at term with mild labour pains. The findings on examination were:

General examination: General condition fair; pulse 96/mn; no pallor; B.P. 146/90 mn; pitting oedema around ankles and on feet temperature, normal.

Per abdomen: Fundal height, 36 weeks' size, uterus was of long, linear type without a normal width. Vertex was presenting with station above brim. F.H.S.s were present and regular, 140 per minute.

Per vaginam: Os was one finger, cervix was hanging loose; bag of waters was intact; pelvis was normal in shape and capacity on clinical evaluation.

On admission she was given pethidine 100 mg. intramuscularly. Labour pains subsided and she was subsequently put on Navidrex and Siquil. F.H.S.s were checked repeatedly and her blood pressure maintained with this treatment. On 28th September she complained of leaking without any pains; she was given a full medical induction with unitocin (5 amp). She had pains after unitocin but the cervix did not dilate beyond two fingers and the head did not descend though the caput started forming. . At this stage it was decided to do a caesarean section in the interest of the foetus.

Laparotomy findings:

On opening the abdomen on 29th September, a diagnosis of pregnancy in unicornuate uterus was made. The following interesting features were noted:

(a) Lower segment was not at all formed.

(b) Uterus was long, reaching right up to xiphisternum but very linear.

(c) Right fallopian tube, ovary and round ligament were normal in shape, size and situation.

(d) There was no round ligament on the left side, and left tube and ovary were absent from their normal situation.

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Received for publication on 20-1-68.

(e) A loose fold of peritoneum (about 2″) was seen covering the upper part of cervix.

(f) Left fallopian tube which was very small and left ovary (long, linear and appeared non-functioning) were stituated at the level of the internal os, and the tube was seen to disappear into the loose fold of peritoneum covering the cervix.

(g) Musculature of upper segement was hardly as thick as that of a normal term pregnant lower segment.

(h) Placenta was small and of circumvallate type.

(i) Baby, though at full-term, weighed only 4½ lbs.

She was delivered by an upper segment caesarean section. The mother and baby were discharged in good condition on 8-10-67.

Discussion

It seems that in this case the caudovertical part of the left fallopian tube did not develop at all but the craniovertical and middle horizontal parts were normally developed resulting in the formation of left tube which, probably due to the failure of formation of left gubernaculum (future round ligament), had an abnormal descent. Eastman has mentioned the possibility of exactly the same anatomical situation.

Recurrent threats of abortion in the 2nd trimester can be explained as due to the development of a single horn and consequently poor musculature, limiting the distensile capacity and alteration in shape of the uterus, so very necessary to accommodate the growing embryo.

Labour did not progress after full medical induction and unitocin in spite of fairly good uterine contractions, and this was probably due to two reasons, one, because of absence of formation of lower segment, the head failed to descend and apply itself to the cervix. The close application of the presenting part to the cervix, besides having a mechanical effect on dilatation, provokes a reflex action by pressing upon the cervix further augmenting uterine contractions. The second possibility is that the cervix, though anatomically normal, was not functionally so and hence failed to dilate. How far the partly developed uterine musculature was responsible for the unsatisfactory progress of labour, is difficult to comment upon because even grand multiparae with fibrosis uteri have good uterine activity and an easy labour.

It was rather interesting to note that though the patient was full-term, the baby was under weight (4½ lbs). The foetal growth seems to have been hampered by the limited space in the uterine cavity due to poorly developed musculature and hence limited hypertrophy and distensile capacity. Another possible contributory factor seems to be the small placenta. However, all the reflexes of the baby were normal.

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