

VIALBLE PREGNANCY IN UNICORNUATE UTERUS

(Report of two cases)

by

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Congenital developmental anomalies of the female genital tract are frequently diagnosed during investigations for the cause of infertility or for a previous bad obstetric history. Unicornuate uterus is the least common of all the developmental anomalies. Ogilvie (1957) in his review of literature found only 53 cases of true unicornate uterus.

Case 1

Mrs. R.R.K., age 28, a primigravida, Hindu house wife from a low income group family, was admitted on 8-7-1971 as an emergency case with labour pains and 'show' since three hours. She was a booked case. L.M.P.—30th November, 1970.

Past Menstrual History. Menarche 15 yrs. Previous cycles, 28 ± 2 days, flow average, 3-4 days, severe premenstrual pain since menarche.

History of Past Illness: Patient had a congenital rectovaginal fistula with a vestibular anus which was not repaired during childhood. She was operated for acute intestinal obstruction in 1963 (definite pathology could not be traced since patient lost old records). Patient had a successful reconstruction of the vestibular anus in 1967.

Family History: Not significant

General Examination: General condition fair-average built, height 150 cms. Pulse/Respiration 80/20 p.m. B.P. 138/90 mm of Hg.

Anaemia +, Hb-9 gms% oedema feet.—nil.

Urine-albumin-trace.

Systemic Examination—nothing abnormal detected.

Obstetric Examination

The abdomen was enlarged. Height of the fundus corresponded to the period of amenorrhoea-32 weeks, but the fundus was markedly deviated to the right side. Attempts to correct the attitude of the fundus to midposition failed. Head presenting engaged, back to the right, F.H.S. +.

Per Vaginam

Cervix half effaced, os, 2 fingers dilated, bag of membranes felt. Head well adapted to the cervix. Pelvis clinically adequate, uterine contractions satisfactory.

Normal vaginal delivery of a premature infant was expected, Patient was sedated with 100 mgm pethidine hydrochlor and 25 mg. sparine intramuscularly.

Patient delivered normally after 3 hours, premature living male baby, birth weight 3 lb-12 oz. Placenta and membranes retained for 30 minutes without bleeding.

Manual removal of the placenta was done under general anaesthesia with gas and oxygen. The placenta was found adherent at the fundus and the right cornua. During manual removal, the uterine cavity was found deviated to the right and no left cornua could be demonstrated during exploration. The left wall of the uterus was smooth. Patient had an uneventful puerperium and the patient was discharged well, on the seventh day, with advice to come for follow up in the post natal clinic after eight weeks.

Follow up at 8 weeks

General condition—fair, Hb. 12 gm%,

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B.P. 120/80 mm of Hg, Per Abdomen—Nothing agnormal detected. Urine, albumin—nil.

Per Vaginam—external genitalia—healthy, episiotomy scar union good. Uterus—normal in size, anteverted with extreme deviation to the right. Right appendages palpable, left side of the pelvis empty.

Hysterosalpingography (Fig. 1)—Shows extreme deviation of the body of the uterus, with only one right patent tube showing spilling.

Descending pyelography—demonstrated delayed renal function of the right kidney only with right hydroureter.

Case 2

Mrs. S.M., aged 29, was admitted as an emergency case on 12-10-1970 with a history of labour pains for two hours and rupture of membranes. L.M.P.? (Patient conceived during lactational amenorrhoea) Last child birth 2½ years ago. She was a booked case.

Personal History: Married for 8 years

Past Menstrual History: Menarche—13 yrs. Past cycles 28 ± 2 days, flow average, 3-4 days, pain + relieved with antispasmodics since menarche.

Obstetric History: First conception occurred 4 yrs, after marriage and ended in spontaneous abortion at 10 weeks of pregnancy. Second pregnancy soon after the first abortion and terminated at 16 weeks. She delivered a premature male baby normally at 34-36 wks in 1968, birth weight 4 lb. 2 oz. The baby was nursed till the patient felt the quickening of the current conception.

History of past illness: Patient had pneumonia at the age of 10 and infective hepatitis at 12 years of age.

Family History of illness: Nothing suggestive.

On Examination: General condition fair, height 155 cms., weight 110 lbs. Pulse/Respiration-72/18 pm, B.P. 124/72 mm of Hg, Hb-12.2 gm%. Urine. Albumin—nil.

Systemic Examination: Nothing abnormal detected.

Obstetric Examination: Uterus, full term, deviated to the right under the right hypochondrium. Attempts to correct the attitude failed. Head presenting, engaged,

back to the right. Foetal heart sounds, 144 per minute regular. Uterine contractions satisfactory.

Per vaginam-cervix half taken up, os 2 cm open—membranes absent. Head well adapted to the cervix, pelvis clinically adequate.

Patient was sedated with injection of pethidine hydrochlor 100 mg. and sparine 25 mg. intramuscularly. Two hours after admission foetal heart rate became irregular, ranging persistently between 120-126 per minute and on vaginal examination there was no progress of labour. Uterine contractions strong. The liquor gradually drained out with meconium staining. Oxygen inhalation to the mother did not improve the foetal heart rate. Caesarean section was performed for foetal distress. The patient requested for sterilisation if the new born survived.

The abdomen was opened by right paramedian vertical incision. The uterus was deviated to the right side. The obliquity of the uterus was corrected and lower segment caesarean section was performed without difficulty. There were three loops of cord round the neck of the foetus, thus explaining the cause of foetal distress. Live male baby, birth weight 4 lb 12 oz was revived easily. While doing tubal sterilisation, right tube and ovary were found hypertrophied with thickened right round ligament. To our surprise the left side was empty, showing complete absence of the left adnexa and the left broad ligament. There was small aggregation of fibres under the anterior peritoneum simulating the round ligament of the left side, which had a much lower insertion. The peritoneal reflection on the left side was directly on to the bladder. The abdomen was closed in layers. The puerperium was uneventful and the patient was discharged well with the baby on the 10th day. Descending pyelography showed functioning normal kidneys on both the sides with no evidence of any bony deformity round the pelvis. The patient failed to turn up for follow up hysterosalpingogram.

Discussions

Opinions vary as regards the possibilities of conception in a unicornuate ute-

rus. Campbell (1933), Stander (1941), De lee and Greenhill (1947) are of the opinion that full term pregnancy can be expected in a unicornuate uterus. Munro Kerr and Chasser Moir on the other hand comment that this abnormality is a rarity and conception in these cases is still more uncommon. The first case had multiple congenital abnormalities and had conceived eight years after marriage suggest a low conception rate, but the second case with definite evidence of failure of development of the Mullerian system of one side had four pregnancies in eight years. Campbell (1951) studied the association of developmental abnormalities of the urinary tract with major degrees of genital abnormalities in the female and found co-existing abnormalities of the urinary tract in one third of the cases. Ogilvie (1957) in his review of 53 cases found renal agenesis in 70 per cent of the case of known unicornuate uterus.

Summary and Conclusion

Two cases of viable pregnancies in unicornuate uterus were accidentally diagnosed out of 18,000 confinements during 1970 and upto September 1971 at the Eden Hospital. The first case with one poorly functioning kidney has been advised against further conceptions in view of possible renal complication and renal

failure. The repeated miscarriages at different periods of early pregnancy in the second case could have possibly been due to the abnormality of the uterus which failed to stretch in the first two conceptions.

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See Fig. on Art Paper I