HAEMATOCOLLIS IN UTERUS DIDELPHYS

by

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Occlusion of the cervix may be congenital or acquired. The latter is more-common usually being due to surgical procedures on the cervix like amputation, cauterisation, infective lesions like tuberculosis, effect of radiotherapy or application of chemical irritants as in the case reported by Dass *et al* (1971). The congenital occlusion is extremely rare. Jeffcoate (1969) is of the opinion that th congenital occlusion of the cervix is an extremely rare condition. He has encoun tered only one patient of congenital cervical obstruction. He further states tha the so called haematometra or haematocervix seen in cases of atresia of the vagina is usually due to an obstruction in the upper vagina leading to cystic dilatation of the cervix incorporating the part of the vagina above the level of the obstruction. Congenital atresia of the cervix leading to haematocervix only seems to be still rarer. Rarest perhaps is the occurrence of haematocervix alone in uterus didelphys. Two cases of uterus didelphys with haematocollis are being reported.

Case I

Mrs. K. B. was admitted to Tata Main Hospital on 23-3-1970, complaining of pain in the left iliac fossa. She was para-2, both pregnancies ending in premature labour at the 8th month. Both of the babies died within 3 months of birth due to prematurity. The pain in the left iliac fossa started soon after the last childbirth and tended to get worse during menstruation. The menstrual cycles were normal $\frac{3\text{-}4}{30 \text{ days}}$. Pelvic examination revealed a normal sized, retroverted uterus with a firm tender mass in the left fornix adherent to the pelvic wall. Left external iliac tubercular lymphadenitis and left parametritis were considered in differential diagnosis.

Investigations: Haemogram and erythrocyte sedimentation rate were normal. Skiagram of the chest showed clear lung fields. X-ray of the pelvis did not reveal any abnormality excepting slight symphysial separation. Cystogram and barium enema findings were normal. V.D.R.L. and Kahn tests were negative.

The patient was treated with antibiotics, penicillin and streptomycin without any relief of pain. On 18-5-1970, she was readmitted with pain considerably aggravated and a laparotomy was decided upon.

On 23-5-1970, a laparatomy was done. A didelphys uterus was seen. The left half of the uterus was situated far to the left in the iliac fossa, separated by a peritoneal fold from the right half, which was near midline. The body of the left uterus was normal with normal left fallopian tube and ovary. The left cervix was deeply embedded in the broad ligament with bluish cystic dilatation containing accumulated old blood (Fig. 1). As the enucleation of the haematocervix was difficult and considered risky in view of the firm embedding very close to the big blood vessels, the ureter and the bladder, a subtotal hysterectomy was done on the left uterus leaving behind the dilated cervix afer removing the blood clots from the cystic space which was allowed to obliterate spontaneously.

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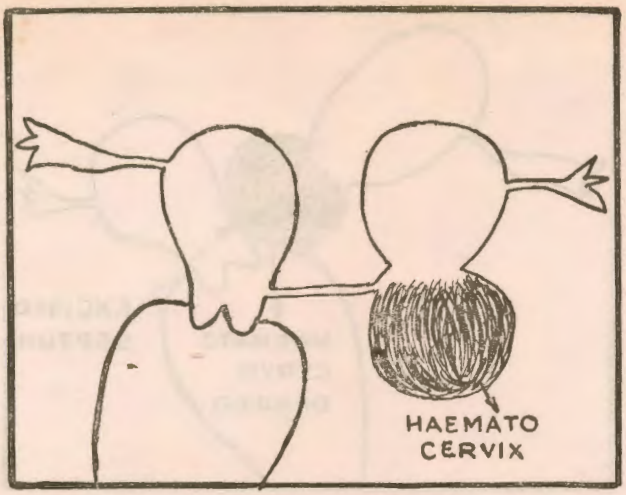

Fig. 1
Shows the uterus didelphys with Haematocollis in left half.

The patient made an uneventful recovery. A follow-up examination after two months showed slight induration in the left adnexal region. The patient was completely relieved of the pain.

Case II

Mrs. S. S., aged 20 years was admitted on the 13th August, 1970, with pain in the hypogastrium referred to the right sacro-iliac joint and anal canal. The pain increased in the sitting posture. She was married only seven months before admission. Her menstrual cycles were normal and regular $\frac{5}{30 \text{ days}}$. At the time of admission she had an early onset of bleeding per vaginam on the 23rd day of cycle. There was a history of similar attack of pain soon after her menarche at the age of 13 years.

On Examination: The hypogastrium was tender. Vaginal examination revealed two uterine swellings, the right one riding over a cystic tender mass felt through the vagina in the right fornix. The portiovaginalis cervix felt through the vagina was thought to be continuous with the left sided uterine body.

An examination under anaesthesia on 17-8-1970 confirmed the original pelvic findings. A sound passed through the cervix led to the left sided uterine body. A diagnosis of uterus didelphys with haematocervix on the right side was made. Laparotomy was done on 20-8-1970 and the diagnosis was confirmed (Fig. 2). The bladder was dissected off the cystic haematocervix on the right side and an incision was made on the anterior surface. A large amount of sanguino-purulent material was drained out. Digital exploration of the cystic cavity showed the presence of arbor vitae confirming the haematocervix. The finger in the cystic cavity helped localisation and establishment of vaginal opening by an incision in the right vault very close to the normal looking cervix of the left side.

As the vaginal opening of the right sided uterus was considered liable to cicatrisation and future closure, the septum between the two cervices was widely excised vaginally, thereby securing one common dilated cervical canal into which the two uterine bodies opened on two sides.

The patient made uneventful recovery and during follow-up examination no stenosis was detected. She was completely relieved of pain.

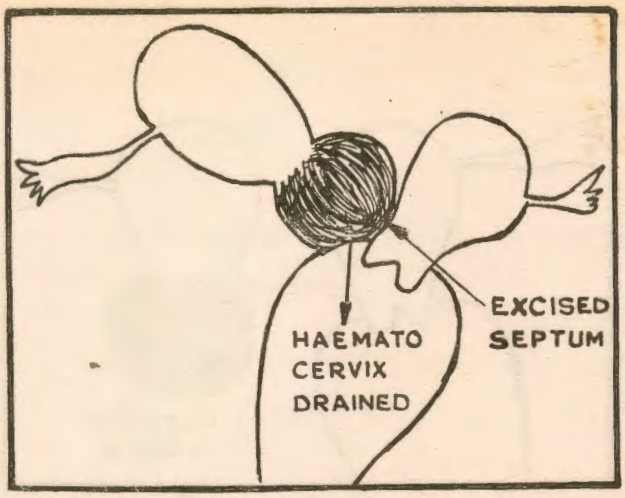

Fig. 2
Shows the uterus didelphys with Haematocervix of the right half. The sites of vaginal drainage and excised septum are shown.

Discussion

Two cases reported above are of interets because of rarity of haematocervix, specially in an uterus didelphys. Case I had the two halves of the uterus widely separated from each other. This type of anomaly is sometimes called uterus pseudodidelphys. In this case the obstetric history is typical of a congenitally malformed uterus in that both the pregnancies ended prematurely. What is of greater interest is that the constant pain came on after the second childbirth. Possibly, this left half was functionally more rudimentary and it was the high levels of hormones during the two pregnancies that initiated menstrual flow for which there was no outlet leading to haematocervix. Another interesting feature of this patient was that the left half of the uterus was far out near the pelvic wall. In some women this half may be rudimentary enough to be in a hernial sac (Jeffcoate 1957). The subtotal hysterectomy in this patient relieved the pain obviously by stopping further accumulation of blood in the cervix of haematocervix.

In case II, the first symptom of pain appeared soon after the menarch indicating the beginning of accumulatio of blood in the cervix of the right an occluded half of the uterus. The pain of distended haematocervix was referred to the sacrum and anal region apparently because of the stretching of uterosacral ligament. Combined abdomino-vaginal approach was undertaken in this patient only to avoid damage to the bladder or the ureter. Attempt was made blindly to drain the haematocervix through the vagina. Later the septum between the two cervices was excised with the object of preventing subsequent stenosis of the small artificial vaginal opening of th right half of the uterus.

Haematometra is the common sequel of cervical occlusion. None of the 13 cases

of cervical atresiae reported by Masani (1967) had any haematocervix even though there were 6 cases of congenital obstruction. The haematocollis reported by Dass *et al* (1971) was due to an acquired cause. Jeffcoate (1969) mentioned about the case of congenital occlusion of cervix seen by him but has not given any further details about it. The two cases of haematocervix reported by him in the same paper were considered by him to be due to retention of blood not only in the cervix but also in an upper compartment of the vagina. In other words, these were not cases of true haematocervix. Jeffcoate (1969) has stressed the point that there should be a normal vagina in case of congenital occlusion of cervix. In our two cases there was one normal vagina in each. Review of published reports show that the occurrence of haematocervix in uterus didelphys is extremely rare.

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