OBSTRUCTED LABOUR DUE TO CONGENITAL MALFORMATION

by

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It is a well known fact that although complete or partial fusion or incomplete development of Mullerian ducts results in different types of congenital abnormalities of uterus and vagina, they are still passed unnoticed by many experienced obstetricians. The main reason for this common mistake is that, very often they are symptomless. The majority are first recognised during pregnancy or as a result of pergnancy mishap, which shows that, as a rule, they do not materially affect fertility.

Even though several varieties of uterus pseudodidelphys have been noted, the incidence of true-uterusdidelphys i.e. with a complete duplication of urogenital tract viz. tubes, uterine body, cervix, vagina, vulva, bladder and urethra is extremely rare. One or other type of these developmental anomalies has been present in 1.1 to 3.5 of all women (Strassmann) and 0.3% of all deliveries. Why in some cases the two Mullerian ducts fail to fuse normally and completely is not definitely known. The two Mullerian ducts are ordinarily pulled together by subperitoneal fibromuscular tissue and it is suggested that a defect in this is a cause of these malformations or the presence of unusually thick round ligaments and a tough vesico-rectal fold running between each horn may pull the two ducts apart.

Cases are sometimes missed leading to interesting obstetric mishaps. Many instances are recorded where experts have failed to rupture artificially the membranes in a case of pre-eclamptic toxaemia, because all of them had tried to do so through the cervix of the non-pregnant second uterus.

An interesting case of obstructed labour due to congenital malformation, the first of its kind treated at Govt. Medical College, Surat, is reported here.

Case Report

Mrs. X, age 25 years, primigravida, having 9 months amenorrhoea was admitted at the Old Civil Hospital on 29-6-70 at 5 p.m. as an emergency case. She gave a history of labour pains and leaking of membranes since last 24 hours. She had been admitted and kept under observation at Ukai Hospital (70 miles from Surat) for about 24 hours, and was transferred here as she failed to make satisfactory progress in labuor.

Menstrual cycles were normal with no history of dysmenorrhoea, dyspareunia or menorrhagia. L.M.P. was not known. Her pregnancy so far was uneventful.

Her general condition was satisfactory except for the signs of exhaustion. B.P. 110/70, pulse 100/m tongue was dry. No oedema on feet. Hb% 8.5 gm%. Urine—clear. Blood group B, Rh + ve. Heart and lungs were normal.

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Per abdomen, uterus was full term size. Mild uterine contractions at intervals of 7 to 10 minutes, lasting for about half a minute were felt. Half of the head was felt per abdomen. Anterior shoulder was difficult to palpate. Lower uterine segment was stretched, but not tender. Foetal heart sounds were regular, 136 per minute.

On vaginal examination a fleshy, thick vaginal septum extending from about 2 cm. above the introitus and reaching few cms. below the external urinary meatus was felt. On the right side of the septum an almost fully dilated cervix with a thin rim was felt and an oedematous, undilated cervical lip was felt to its left which was difficult to identify separately from the dilated cervix on the right side. Lowest part of the head was 2 cm. above the spines. Membranes were absent. Caput + with marked moulding of head. Pelvis was difficult to assess due to presence of the vaginal septum.

Per speculum examination done in operation theatre confirmed the presence of a complete vaginal septum described above. Thin dilated cervix was seen on the right side of the septum. On the left, cervix was pushed high, and was difficult to visualise, and identify separately from the lips of dilated cervix on the right.

Probable diagnosis of prolonged labour due to soft tissue obstruction was made and abdomen opened at 7 P.M. On opening the abdomen, the bladder was found to be quite high, about 3 fingers below the umbilicus. Uterus was pear-shaped with some deviation to the right. At this time, no other abnormality could be detected. Lower segment caesarean section was performed in the usual way with delivery of a female child weight 2 Kg. 500 Gms. Baby cried soon after birth. Placenta was situated normally. There was no post partum haemorrhage.

In the presence of a complete vaginal septum, and doubtful presence of double cervix, further exploration was made which revealed the presence of another uterine body, enlarged to about 14 weeks' size lying deeply in the pouch of Douglas, and more or less hidden by the body of uterus on the right side. Each of these uteri contained one normal ovary and tube attached to its cornual end laterally. There was no rectovesical septum. The two uteri were entirely separate from each other with no fusion anywhere. It was difficult to feel or demarcate the cervix of the left horn.

Abdomen was closed in layers. One unit of B + ve blood was given during the operation. Her post-operative course was uneventful. Both mother and baby were discharged on 12-7-70.

X-Ray pelvimetry was done 4 days after the operation, and revealed no abnormality.

She was called for follow up after 3 months. When hysterosalpingography and intravenous pyelography were performed I.V.P. was normal H.S.G. showed the presence of a double uterus and cervix, whereby diagnosis of uterus-pseudodidelphys was confirmed.

Discussion

Many cases of uterus pseudodidelphys are accidentally recognised at laparotomy or during pregnancy or labour. Obstructed labour as a result of impaction of the non-pregnant horn in the pouch of Douglas is sometimes a real problem; but it is very unusual for a complete vaginal septum to prevent the descent of the presenting part. Many a times partial or incomplete vaginal septum overrides the presenting part during its descent through the birth canal. In the case described above, vaginal septum was so thick, fleshy and oedematous, that excision of it would have resulted in severe haemorrhage. In the presence of adequate uterine forces, and no obvious disproportion, one would be tempted to think that excision of septum should have resulted in vaginal delivery. Since 24 hours had already passed with all the liquor having been drained away, it was decided to do a caesarean section in the interest of the mother and baby. The existence of a vaginal septum gave us a good clue to search for other associated abnormality. In spite of having thought about the two cervices, we failed to re-

cognise the presence of the second undilated cervix, since it was pushed quite high up and only the dilated cervix was felt and seen.

On opening the abdomen, the second non-pregnant horn was not seen anywhere, till after the baby was delivered from the pregnant horn.

It is quite possible that the non-pregnant horn in the pouch of Douglas might have descended into the pelvis following the evacuation of the pregnant horn, as intra-partum examination did not reveal its presence. For treatment every case should be considered on its own merits. Routine speculum examination of all cases in labour, sometimes proves of a great help. Even though many a times, vaginal septum may be the sole congenital abnormality present, one should look for other associated abnormalities, either clinically, if such cases are met with in labour or by hysterosalpigography in the non-pregnant state.

Summary

A case of obstructed labour due to congenital vaginal septum is presented. At laparotomy it turned out to be pregnancy in uterus pseudodidelphys. Various pitfalls in diagnosis and treatment are discussed.

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References

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