FULL TERM RUDIMENTARY HORN PREGNANCY

(A Case Report)

by

VANDANA WALVEKAR,* M.D., D.G.O., D.F.P.

and

S. D. KANITKAR,* M.D., F.C.P.S.

Ectopic gestation being so varied in its pathology and clinical course is a source of continued interest to obstetricians and gynaecologists. Pregnancy in a rudimentary horn of the uterus is a rare form of ectopic gestation, its incidence being 0.1 of all ectopic gestations according to Jarcho. An Indian author, Subhadradevi gives a higher incidence, 1%, among ectopic gestations.

Rudimentary horn pregnancy was first diagnosed by Vassal and Mauriceau in 1669. This rare form of ectopic implantation of ovum occurs in the rudimentary horn of a uterus through external migration of ovum in most of the cases. The rudimentary horn may be small and atrophic or may be well developed and almost like the cornu of a bicornuate uterus. This being the case, it has been observed as early as in 1883 by Sanger, that most cases of rudimentary horn pregnancies may rupture during 4th or 5th month of gestation. Jeffcoate also gives the time of rupture as 12-20 weeks.

The connecting band of the rudimentary horn is also subject to many variables. It may be muscular, sessile and broad, or thin, fibrous and pedunculated. The communication of this horn to the main uterine cavity in majority of cases is absent. Kehrer has given a 78% and Piquand gives an 85% incidence where there is no connection between the uterine cavity and that of th horn.

Author	Period of gestation months	Parity	Age Yrs.	Baby	Patency
Masani	14	-	24	Dead	No Patency
Subhadradevi	11½	Primi	10	Dead	?
Naidu	7½	Multi	30	Dead	Nil
Present Case	9	Primi	24	Dead	Nil

Three cases of advanced rudimentary horn pregnancy have been reported by the above authors and in no case the patency could be demonstrated between the uterine cavity and the cavity of the rudimentary horn.

*Department of Obst. & Gynec., L. T. M. G. Hospital and L. T. M. M. College, Sion, Bombay-22 (DD).

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CASE REPORT

Mrs. D.D., 24 years old, primigravida was transferred from a peripheral maternity home for 9 months' amenorrhoea with toxaemia of pregnancy, the foetus presented by breech. She also had umbilical cellulitis. She was admitted in the hospital and was investigated.

On examination, the patient was of average build and nourishment, a blood pressure of 140/90 mm. of Hg. was recorded. Oedema of feet was present.

Per abdomen examination revealed marked cellulitis and profuse discharge from the enlarged, infected umbilicus. The foetus was in left sacro anterior position. Version was tried but was unsuccessful. Patient gave history of doubtful foetal movements for 3-4 days. Foetal heart sounds could not be heard. On vaginal examination the cervix was firm and closed. There was no vaginal bleeding.

Investigations: Haemoglobin 10.0 gms.% Urine-NAD, blood urea NPN and Sugar were within normal limits, sonicaid was negative at two separate examinations. Biological pregnancy test also was negative and an X-ray of the abdomen showed evidence of intrauterine death of the foetus, in what looked like a uterus from the soft tissue shadow. It was decided to induce labour with pitocin drip. For two days pitocin drip was given in increasing doses without any effect and without ripening of the cervix. Sounding of the uterus and hysterosalpingography later confirmed the suspicion of exterauterine pregnancy. An exploratory laparotomy was then performed.

A normal size uterus, tube and ovary of the right side were seen. A muscular band was connecting the uterus and the gestation sac. The round ligament, left tube and ovary were lateral to the gestation sac, proving it to be a rudimentary horn pregnancy. Clinically, no evidence of patency with the uterine cavity was present. The gestation sac was adherent to the undersurface of the infected umbilicus and no communication was seen. Corpus luteum was seen in the left ovary. The dead foetus was removed. As much as possible of gestation sac was excised, and abdomen was closed. Post-operative period was uneventful.

FOLLOW UP

Patient was called again after 8 weeks for a repeat hysterosalpingography which revealed a unicornuate uterus with no evidence of patency either with the remnant of the gestation sac or with the umbilicus.

Discussion

Such a rare case always presents difficulties in diagnosis and management. The case described by Subhadradevi was treated as an ectopic gestation. The same treatment was given to Naidu's case. Kishore and Pathak further report that management of rudimentary horn pregnancy was carried with an induction with pitocin drip with a diagnosis of intrauterine death of the foetus. Present case, however, was diagnosed after failure of induction of labour and laparotomy was performed. Thus, various types of presenting features of an ectopic pregnancy continue to tax the resources of the obstetrician.

Summary

A case report of full term rudimentary horn pregnancy is given above with the management of the same.

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