TWIN PREGNANCY IN UTERUS DIDELPHYS

(A Case Report)

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Congenital malformations of the female reproductive tract have always been a topic of considerable interest among gynaecologist and obstetricians. In recent years it is found that either malformations are responsible for sterility or infertility while during pregnancy unusual and difficult obstetrical problems are faced.

The authors came across a single case of true uterus didelphys in which complete failure of midline fusion of Mullerian ducts resulted in development of double uterus, each with its separate cervix and vaginal tract and that too associated with pregnancy in each cavity of the uterus didelphys. The rarity of this combination has prompted us to publish the present case.

Case Report

Mrs. M.S., married, aged 19 years was admitted in J.L.N. Zanana Hospital, Ajmer, on 17-7-1972 with history of amenorrhoea (last menstrual period on 5th Feb., 1972) pain in the lower abdomen and profuse vaginal bleeding with passage of blood clots for one day. The menarche had occurred at 13 years. The menstrual cycles were regular at 7-8/30 days and were not associated with dysmenorrhoea.

Obstetric History: 1st premature labour at thirty weeks of gestation at her home 4 years back, Baby died after 12 hours of prematurity. Second pregnancy ended in abortion for which she was admitted in this hospital on 7-8-1970 in emergency as a case of incomplete abortion with mass in right fornix. At that time she had amenorrhoea of 2 months with abdominal pain and profuse vaginal bleeding. On vaginal examination, os was open, product of conception were felt in the cervical canal; uterus was 6 weeks' pregnant size. A mass, size 2″ × 2″, was felt in right fornix. Products of conception were removed digitally by the house surgeon but still some placental pieces were found adherent in the uterine cavity. As patient had her full meal, she was posted for evacuation under anaesthesia on next day. On 8-8-1970, under general anaesthesia, a diagnosis of uterus didelphys with double cervix with a median septum involving the whole length of the vagina was made. On the left side the uterus was approximately the size of 6 weeks gestation with the cervix dilated and placental pieces felt in the uterine cavity. Length of cavity was 3½″. Evacuation was done on that side. The right uterus was normal in size and os was closed. Length of cavity was 3″. The mass which was felt in the right fornix was the seperate uterus. Dilatation and curettage was done and endometrium was saved. Excision of vaginal septum was done. She was discharged 7 days later.

Histopathological report: Endometrium in proliferative phase with moderate dilatation of glands.

On Examination: Patient was fairly built and nourished. There was no oedema of feet. Pulse 80/minute, B.P. 100/60 mmHg.

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Heart and lungs normal. Hb—10 G% TRBC —5 million/cumm. Urine: Alb.—nil, sugar —nil, Micro—NAD. Blood K.T. negative.

Per-Abdomen: Uterus was enlarged to 22 weeks' gestation. Foetal parts were ballotable and foetal heart sounds were heard.

Pelvic Examination: Two cervixes were identified. The left cervix was soft, os was open and products of conception were protuding through the os which were removed digitally and uterus was 8 weeks size. The right cervix was soft, os was closed and uterus was 22 weeks gestation size.

A diagnosis of double pregnancy in a uterus didelphys with incomplete abortion on left side was made.

Under general anaesthesia placental pieces were removed from the left uterus with ovum forceps and then blunt curettage was done. The specimen was saved.

Histopathological Report: The specimen shows products of conception.

The right uterus became slightly irritable but did not exhibit regular contractions and there was no dilatation of the cervical os. Patient was discharged after 11 days. The prenatal period proceeded uneventfully.

She was re-admitted on Nov. 8, 1972 at 11.30 P.M. with labour pains. On abdominal examination uterus was 36 weeks' size with fundus pushed more towards the right, vertex presenting, right occipito-anterior position and head was engaged. Uterine contractions were good and regular, foetal heart sounds were 140/min. and good in volume. No separate mass was felt on the left side.

On vaginal examination, right cervix was effaced and approximately 7 cm. dilated, membranes present, vertex in the mid cavity and bony pelvis was average gynaecoid type. The left cervix was closed and was pushed more to left side. The left uterus was felt separately in the left fornix and was normal in size. Spontaneous rupture of membranes occurred after 3 hours and a living premature female infant of 4¼ lbs was delivered normally. Baby breathed and cried spontaneously. The placenta was delivered intact in 20 minutes with a blood loss about 200 c.c. There was no perineal tear. Postpartum period was uneventful. Patient was discharged on 7th day.

On Feb. 3, 1973, she came for post-natal checkup. At that time, on vaginal examination, both cervical os were found closed, both uteri were well involuted, the left uterus was slightly smaller in size as compared to the right one. Fornices were free. She was advised to come for hysterogram but she refused.

Discussion

The diagnosis of congenital uterine anomalies is often not made at all or come as a complete surprise during management of a major obstetric difficulty. At other times it is made during investigation of patients with sterility or inadvertently during curettage. During pregnancy, unusually broad or notched fundus or deviation of the uterine axis or abnormal lie of the foetus usually arouse the suspicion of malformation.

Twin pregnancy in uterus didelphys is not common. Polak (1923), stated that a single pregnancy is seven times more common than double in uterus didelphys. Eighty-eight reported cases of complete uterine duplication were associated with seven multiple pregnancies and 136 single pregnancies. This represent an incidence of 1 in 16.5.

In the present case it is interesting to note that both sides of uterus didelphys were not in labour simultaneously, instead there was a considerable interval of 111 days between the abortion from the left uterus and the birth of a living baby from right uterus. William & Cummins (1953), reported an interval of 56 days, it was 20 days in a case of Dorgon & Clark (1956) and was only 5 minutes in Brown's (1956) case. Difference in the duration of gestation suggests superfoetation but this condition is not common in human being. It may be possible that the pregnancy in left uterus resulted in mis-

sed abortion while right uterus continued to grow. The difference in onset of labour suggests that not only structural, hormonal, nervous, nutritional and circulatory factors but a local stimulus also plays a major part in onset of labour.

Brody (1954), Brown (1956), Dorgon & Clark (1956), reported case of twins, one in each horn of a uterus didelphys and were delivered alive vaginally at full term. Bainbridge (1924), quoted a report by Bellighaus of a patient who delivered a full term white infant from the left horn and 2 months later a black infant from the right uterus.

Abortion, premature labour, malpresentation, retained placenta and postpartum haemorrhage are common complications in congenital malformation of uterus mainly due to hypoplasia rather than due to doubling of the uterus. In this case also the left uterus aborted twice mainly because of hypoplasia with an associated factor of excessive irritability of the uterine musculature.

It is strange to note in this case that, when the patient had her first abortion from the left uterus, the right uterus being a non-pregnant did not reveal decidual reaction in the endometrium but instead showed proliferative phase with cystic dilatation of glands. This controversial point could not be explained.

Summary

A case of double pregnancy in a uterus didelphys with incomplete abortion on left side and premature delivery on right side is presented.

Acknowledgement

The authors are thankful to the Principal & Controller of the J. L. N. Medical College Hospitals, Ajmer for permission to use the hospital records & to publish the case.

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