URGENT LAPAROTOMY FOR UNDIAGNOSED HAEMATOMETRA

by

NIRMAL SEN,* M.R.C.O.G.

and

SUPRAIYA SEN GUPTA,** F.R.C.O.G.

Clinical experience in obstetric and gynaecological practice shows that the congenital abnormalities of the female genital organs vary enormously. Strassman (1966) has put the incidence between 1.1 to 3.5% of all women, and 0.3% of all deliveries. Even with a preconcept of the possibilities, the diagnosis is often made only at laparotomy, as an unexpected finding or as a paradoxical conclusion of some provisional clinical diagnosis.

Two cases of haematometra with haematosalpinx in cases of uterus pseudodidelphys, with single normal vagina diagnosed at laparotomy are being presented. In both the cases the two horns were widely separated with cervical occlusion of one horn, and with no communication with the vagina of the blunt horn.

CASE 1

Mrs. A. S., 24 yrs., Para 0 + 0, Hindu house wife, married for 4 years, was admitted with, (i) acute pain on right side of lower abdomen for 2 days, not relieved by antispasmodics, (ii) nausea with occasional vomiting, (iii) Scanty period seven days back.

Menstrual History: Menarche—13 years, cycles 28-30 days regular, flow average, cyclical premenstrual pain in the lower abdomen for 6 years. Patient complained of persistant pain on the right side of the lower abdomen before, during and after the menstruation for past 6 years. Last menstrual period was scanty 7 days back.

Obstetric History: Para 0 + 0. Past History. Nothing suggestive.

Examination:—On Admission: The patient was restless due to the pain, was exhausted and dehydrated. Pulse—110 per minute, respirations, 24 per minute, B.P. 110/70 mm of Hg., Anaemia +, Hb-9 gm%.

Systemic Examination: Heart and lungs — nothing abnormal detected. Abdominal Examination. The lower abdomen was extremely tender, more so on the right side on deep palpation. There was slight muscle guarding.

Vaginal Examination: External genitalia normal, vagina normal in length and rugosity. The uterus was normal in size, deviated to the left. Separate from the uterine fundus there was a firm to tensely cystic mass on the right side. The outline was irregular and obscure. The mass had a restricted mobility and was very tender on movement.

Rectal Examination: The mass was felt on the right and anterior to the rectum; the mobility was restricted.

Routine laboratory investigation for blood and urine showed normal readings.

Immediate laparotomy was decided with a provisional diagnosis of a twisted ovarian cyst with intracystic haemorrhage or disturbed tubal pregnancy. On opening the abdomen it was a case of uterus pseudodidelphys, with haematometra and haematosalpinx on the right side. The right uterine horn was completely separate and was connected to the other uterine horn by a thick tag of membranous tissue. (Fig. 1). Total hysterectomy with salpingo-oophorectomy was done of the accessory uterus, leaving the other normal functioning horn with the normal tube and ovary of that side.

---

*Clinical Tutor—Dept. of Obst. & Gynec. NRS Medical College, Calcutta.

**Associate Professor Dept. of Obst. & Gynec. NRS Medical College, Calcutta.

Received for publication on 18-10-73.

The postoperative recovery was uneventful and the patient was discharged on the 10th day. At follow up six weeks later, the patient was doing well and had a normal painless period on her due date. Hysterosalpingography showed one horn of the uterus with peritoneal spilling through the patent tube. Discending pyelography showed normal functioning kidneys with normal ureters.

CASE 2

Miss K. D. 21 years, college student was admitted with a history of excruciating pain in the lower abdomen—3 days, which was not relieved by antispasmodics and sedatives, nausea with occasional vomiting, Constipation ++.

Menstrual History: Menarche at the age of 14 years, cycles, irregular, 6-7 days, flow moderate, severe pain, spasmodic in nature before, during and after the menstruation in the lower abdomen for the past 6 years. Last menstrual period—16 days back.

Past History: Patient had an emergency laparotomy in 1961 at the age of 10 years for a twisted fimbrial cyst.

General condition fair, patient looked exhausted and anxious as a result of the excruciating pain. Pulse—110 per minute, respirations 20 per minute, BP 116/76 mm of Hg.

Systemic Examination — Heart and lungs—nothing abnormal detected.

Abdominal Examination: The midline infraumbilical scar was healthy. The abdomen was soft with no muscle guarding or rigidity. There was a firm mass felt on deep palpation, arising from the pelvis more on the right side, with well defined outline, slightly mobile and tender on palpation.

Local and Rectal Examination: External genitalia normal, uterus bulky, firm, deviated to the right. A separate mass with restricted mobility was felt on the left side. Generalised tenderness ++.

Routine laboratory investigation of blood and urine gave normal readings.

Examination Under General Anaesthesia: External genitalia normal, single vagina normal in length and rugosity. There was only one cervix, firm and normal in length. The uterus was firm and bulky, deviated to the right. A mass with restricted mobility and separate from the uterus was felt through the left fornix.

On opening the abdomen, the two horns of the uterus were clearly seen, being separated from each other by a thick flat transverse membranous band. The right horn was bulky, globular 4½" in diameter, showing evidence of haematometra. The right ovary was enlarged, studded with small cysts and the right tube was thick, adherent with kinks. The right cervix was embedded into the supravaginal portion of the left cervix, which in turn opened into the vaginal canal. The fundus was split open, draining the old organised menstrual blood clots (Fig. 2). A probe was introduced to explore the possible communications of the two cervical canals. The right uterine cavity was blocked in the lower half showing no evidence of cervical patency. Subtotal hysterectomy was done, resecting the right horn of the uterus with the polycystic ovary and the tube of that side. The cervical stump of the right horn was secured and peritonised. Plication of the left round ligament was done to correct the attitude of the left horn of the uterus.

The postoperative recovery was uneventful and the patient was discharged on the 12th day. At follow up after 8 weeks the patient was doing well. Menstruation had occurred and was painless. Descending pyelography showed normal functioning kidneys and ureters.

Discussion

Milder degrees of congenital malformations of the female genital tract are fairly common and they often pass undiagnosed, if asymptomatic. During investigations for infertility, unsuccessful pregnancies or menstrual disorders some form of minor defects are often detected and confirmed radiologically. Minor to major abnormalities are occassionally traced from the obstetrical career of the patient, with history of repeated unsuccessful pregnancies, premature labours, repeated malpresentations retained placenta etc. Jeffcoate (1962) reported a case where more than one caesarean section had been performed for non-dilatation and possible obstruction of the non-pregnant cervix. Persistent malpresentation in case of uterus pseudodidelphys, leading to the posterior

rupture of the pregnant horn was reported in a case of pregnancy with genital prolapse, where the accessory horn was possibly the cause of obstruction, Sen *et al* (1973). Unsuccessful treatment of spasmodic dysmenorrhoea, menorrhagia, vaginitis and failure of contraceptive measures with the existence of a second horn of the uterus was reported by Das (1969). Associated congenital malformation of the urinary system should always be looked for, since developmental errors of mesonephric and paramesonephric ducts bear close relation. Campbell (1951) studied the association of the developmental abnormalities of the urinary tract with major degrees of genital malformations in the female and found a coexisting abnormality in one third of the cases.

The correction of the abnormality by surgery depends upon the degree of malformation. Minor congenital defects may not require any interference since they present no problem, either for menstrual function or childbearing. Bicornuate uterus is successfully treated by utriculoplasty, and Strassman (1966) claimed a success rate of 74.9% of pregnancies following surgical correction of the congenital abnormality. Das Gupta (1973) made a canalisation and communication of one of the accessory cervix by making an opening in the vaginal vault. In our cases, however, the cervix was not canalised and non-communicating with the vagina and thus a radical approach was rational. In the first case the tube was distended and had obviously lost its physiological function. In the second case, the chances of permanent patency of the artificially constructed cervical canal was a question and to avoid possible recurrence of the pathology, unilateral hysterectomy with salpingo-oophorectomy was done. In both the cases, during follow up investigation, the preserved uterine horn showed normal canal with patency of the respective tube. Conception and successful pregnancy in unicornuate uterus is rare but possible, Sen (1972).

Summary

Two cases of extreme degrees of congenital abnormality of the female genital organs are reported, where diagnosis was made only at laparotomy.

Acknowledgement

We are thankful to Dr. D. L. Poddar, Director Professor, Dept. of Obst. & Gynec. N. R. S. Medical College, Calcutta for his constant encouragement and to Surgeon Commodore Dr. G. C. Mukherjee, Principal Supdt. N. R. S. Medical College, Calcutta, for his kind permission to publish hospital records.

References

1. Campbell, A. M.: Clinical Pediatric Urology, Sanders, Philadelphia—1951.
2. Das, R. K.: Jour. of Obst. & Gynec. of India, **19**: 122, 1969.
3. Das Gupta, S.: Jour. of Obst & Gynec. of India, **23**: 216, 1973.
4. Jeffcoate, T. N. A.: Principle of Gynaecology—1962.
6. Sen, N., Roy, A. and Mitra, A.: Jour. of Obst. and Gynec. of India, **23**: 209, 1973.
7. Strassman, E. O.: Fertil and Steril. **17**: 166. 1966.