

RUPTURED ECTOPIC PREGNANCY IN RUDIMENTARY HORN OF UTERUS PRESENTING AS ACUTE INTESTINAL OBSTRUCTION

(A Case Report)

by

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Ectopic gestation being so varied in its pathology and clinical course is a source of continued interest to obstetricians and gynaecologists. Rudimentary horn of the uterus is a rare congenital abnormality. Sometimes the pregnancy does occur in this rudimentary horn but the phenomenon is extremely rare, 0.1% of all gestation according to Jarcho. Subhadra-devi (1971) gives a higher incidence of 1%. Vassal and Mauriceau (1669) were first to describe pregnancy in rudimentary horn. It has been observed in 1883 by Sanger that most cases of such pregnancy rupture during the fourth or the fifth month of gestation. Jeffcoate (1967) also gives the time of rupture as 12-20 weeks. A case of ectopic pregnancy in rudimentary horn is presented here which was diagnosed only when the abdomen was opened for acute intestinal obstruction.

CASE REPORT

Mrs. S. R. 19 years, primigravida, married 2 years back was admitted on 28.5.73 in Sur-

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gical Department of L. L. R. Hospital, Kanpur, with complaints of amenorrhoea for 4 months and severe colicky abdominal pain starting near the umbilicus and spreading to the right lower abdomen and later all over the abdomen for the last 2 days, which was gradually increasing accompanied by vomiting, absolute constipation and distention of abdomen. She also complained of severe weakness, fainting attacks due to pain and low fever. She did not pass urine for the last two days. No H/o discharge per vaginam, No H/o pain in the shoulder.

Menstrual History:—Menarche—13 yrs, past cycle—30 days \pm 2 days, duration 5 days, bleeding moderate with clots and pain in hypogastrium for first 2 days of periods. L.M.P.—27.1.1974.

Examination:

She was of average built. Her general condition was low. Pulse 140/mt, respiration 40/mt, temperature 99°F and blood pressure 86mm of Hg systolic. No oedema

On abdominal examination there was generalised rigidity and tenderness with fullness in both iliac fossae. Abdomen was not moving with respiration. Uterus was palpable midway between the umbilicus and the pubic symphysis. Foetal parts and ballotment could not be elicited due to tenderness. Liver dullness was present. Bowel sounds were absent.

On speculum examination vagina was extremely pale and tender. There was no bleeding. On vaginal examination, the cervix was tender on movement, all fornices were full. There was no bleeding. Rectal examination did not reveal any thing significant.

Investigations

Blood examination—Hb 7 gm%, TLC—8200, DLC—P64%, L—32%, M—1%, E—3%, P.C.V.—35%.

Urine examination—Sugar and albumin absent.

X-Ray abdomen in standing position—showed signs of intestinal obstruction, no foetal skeleton could be seen.

Operation

Patient was resuscitated by blood transfusion and preparations for urgent laparotomy were done. Under general anaesthesia the abdomen was opened by right lower rectus splitting paramedian incision. Five hundred c.c.s. of blood was present in the peritoneal cavity. There was a lump arising from the pelvis. This was gestation sac formed by the right rudimentary horn of bicornuate uterus. Gestation sac was attached by a broad fibromuscular band to the isthmus of the normal uterus. Size of gestation sac was 12 cms x 10 cms. It had purplish fleshy look. Placenta and foetus were protruding through a rent in the gestation sac. Right ovary, tube and round ligament were lateral to the gestation sac. The main uterus was slightly enlarged due to decidual reaction. Left ovary and fallopian tube were normal.

Blood was sucked out from the peritoneal cavity. Two clamps were applied over fibromuscular band connecting the gestation sac with the uterus and then it was cut. The entire sac was dissected and taken out as a whole. Complete haemostasis was achieved. The stump of the connecting fibromuscular band was transfixed. Abdomen was closed with a drain in plavic cavity.

After two months of operation hysterosalpingogram was done which showed patent left tube. Dye was also seen in small pouch of the stump of fibromuscular band.

Discussion

Female genital organs develop from fusion of two mullerian ducts. In early stage of development human uterus is bicornuate, corresponding in form to the uterus of lower mammalia. Later on, as a result of fusion of two mullerian ducts, a single uterus with a midline

septum is formed. During 5th month of intrauterine life the septum disappears and all that is left of it in adult uterus are the anterior and posterior columns of the mucous membrane of the cervical canal. Failure of fusion occurs in varying degrees and depending upon the degree of failure of fusion and development, various maldevelopments ranging from uterus didelphyus to bi-cornuate uterus with rudimentary horn are observed.

Size of rudimentary horn varies from case to case. Connecting band of rudimentary horn is also subject to variation i.e. it may be muscular, sessile and broad or thin fibrous or pedunculated. This band is usually attached near the isthmus of uterus. The communication of this horn to main uterine cavity in majority of cases is absent, Kehrer has given it as 78% and Piqand gives it as 85% incidence. Masani (1971), Naidu (1960) and Walvekar (1973) also did not find communication in their cases.

Rudimentary horn is otherwise symptomless. It does not interfere with normal pregnancy. When the pregnancy occurs in rudimentary horn it may either rupture or may go into torsion. Rarely the pregnancy may reach to full term. Smaller the size of horn, earlier the pregnancy ruptures. In our case rupture occurred after 16th week. Kehrer showed the incidence of rupture as 47% and Werth as 40% among all pregnancies in rudimentary horn. If the rudimentary horn is loosely hanging then torsion may occur as the pregnancy advances. Cases have also been described when pregnancy has reached full term with or without the foetal death. Tamaskar (1963) reported a case of full term pregnancy in rudimentary horn and could find only 50 such cases in the last 50 years. He also said that normal delivery is impossible

as there is no connection between the rudimentary horn and the normal uterus. Another case is reported by Serejni-Koff in 1898 of a living child delivered from a rudimentary horn which died after 6 hours. In 1951 Scholtz reported a living full term delivery by caesarean section for toxæmia, post-maturity and vaginal bleeding.

Treatment of pregnancy in rudimentary horn is amputation of the horn. Sanger (1883) treated his case by this method for the first time. Kehrer reported the mortality as 13.4%.

Summary

Pregnancy in rudimentary horn is a rare form of ectopic pregnancy. Rupture is the most common complication usually occurring in about fourth or fifth month of pregnancy. Treatment consists of removal of the gravid horn.

References

1. Browne—Quoted by B. Ghosh and M.

Konar. J. Obst. & Gynec. India. 22: 195, 1972.

Jeffcoate, T. N. A., Principal of Gynaecology, 6th ed. 1967. Butterworths and Co. London.

3. Jarcho—as quoted by Chassar Moir in M. Kerr's Operative Obstetrics. P. 733: 1971.
4. Kehrer: Quoted by Latto and Norman. Brit. Med. Jour. 2: 926, 1950.
5. Masani, K. M.: Text book of Gynaecology, Popular Prakashan. 6th ed., 1971.
6. Mehtaji, S.: J. Obst. & Gynec. India, 13: 597, 1963.
7. Naidu, P. M.: J. Obst. & Gynec. Brit. Cwith. 67: 843, 1960.
8. Scholtz, M. J.: Journal of Obst. & Gynec. Brit. Empire; 58: 293, 1971.
9. Sangar, J.: Quoted by Tamaskar, K. P. J. Obst. & Gynec. India; 13: 401, 1973.
10. Serejni, Koff, S.: Quoted by Scholtz, J. Obst. & Gynec. Brit. Empire.
11. Subhadradevi, N.: J. Obst. & Gynaec. India. 21: 400, 1971.
12. Vassal and Mauriceau: Quoted by Narayana Rao, A. V. J. Obst. & Gynaec. India. 13: 591, 1963.
13. Walvekar, W. and Kanitkar, S. D. J. of Obst. & Gynaec. of India; 23: 352, 1973.