UTERUS DIDELPHYS WITH UNILATERAL HAEMATOCOLPOS, HAEMATOMETRA AND HAEMATOSALPINX

(A Case Report)

by

MURALIDHAR RAUT,* M.S.

CASE REPORT

K.P., a 16 year old unmarried girl, was admitted to the Gynaecological ward on 27-12-72 with acute pain in the lower abdomen for last 9 days following a menstrual period. She had her menarche 2½ years previously and the cycles were irregular at 1½ to 2 months with a scanty flow for 3-4 days. The periods were painful. Since about a year the pains increased in amount and persisted for a longer time following the periods. She was admitted 1½ months back to the surgical ward for acute abdomen and tenesmus. She was given conservative treatment and was discharged. The pain persisted and she came again for treatment. Two years back she was operated for chronic osteomyelitis.

On examination, she was of average build with fairly well developed secondary sex characters. Pulse, B.P. and temperature were within normal limits. Systemic examination did not reveal any abnormality.

On abdominal examination an irregular, firm and tender mass with restricted mobility was extending 4" above and to the left of symphysis pubis.

On pelvic examination, a tense, tender and cystic mass was felt 1" above the introitus extending upwards. Fluctuation could be elicited in the mass. On rectal examination, the mass was felt anterior to the rectum and was continuous with the abdominal swelling. A provisional diagnosis of twisted and impacted broad ligament cyst was made.

Her Hb. was 11 gms%, TWBC-6,500/cm, Diff. count within normal limits blood urea-24 mg%, and blood sugar 94 mg%. Straight X-ray of abdomen revealed a soft tissue shadow. I.V.P. done at a later date showed both kidneys and ureters to be normal.

Laparotomy on 3-1-73 revealed a double uterus with haematometra and haematosalpinx on the left side (Fig. 1). After opening the abdomen, an incision was made in the cystic swelling in the vagina and about 450 ml of tarry coloured fluid was drained out. The cavity of the right hemiuterus was opened and it was found that this cavity did not communicate with the haematometra. The left tube was badly damaged by haematosalpinx and left sided salpingectomy was done. The vaginal incision was enlarged and the cut margins stitched: She made a uneventful recovery and was discharged on the tenth postoperative day.

Followup examination on 24-3-73 revealed a double vagina with a septum which was present in the upper 4/5th, lower portion being a single canal. The opening in the septum was patent but not sufficiently open for a speculum to pass easily. The right cervix was found to be small. A hysterogram was attempted under sedation, but the dye leaked out. X-ray was taken with two cannulas in place (Fig. 2). Excision of the septum could not be done as her marriage was to be held by very shortly. She has been advised to come at a later date for the same.

Discussion

This is an unusual case of uterus didelphys with a partial vagina duplex. The left half was imperforate leading to unilateral haemotocolps, haematometra and haematosalpinx. The other half was patent allowing menstruation from the right uterus to occur.

Similar cases as this have been report-

*Asst. Professor, Obstetrics & Gynaecology V. S. S. Medical College, Burla, Sambalpur Dist. Orissa.

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ed by Embray (1950), Merckel *et al,* (1960), Kamm *et al,* (1962) and Chew *et al,* (1970). In most of the reported cases the kidney and the ureter of the same side as the haematocolps were absent. However, both kidneys were normal in the present case. In most cases there is history of severe dysmenorrhoea, backache, pain in the buttocks, which gradually develops into a constant dull aching, and later acute pain in lower abdomen. Of the cases reported few have been diagnosed preoperatively. In the case reported here, diagnosis was made at laparotomy. As the left tube was badly damaged, it was removed. The cases of congenital unilateral gynatrasia should initially be treated conservatively. Hence, the importance of correct diagnosis before treatment is instituted.

Summary

A case of uterus didelphys with vagina duplex, blind on the left side, with unilateral haematocolps, haematometra and haematosalpinx is reported. Diagnosis was done at laparotomy. The importance of correct preoperative diagnosis is stressed.

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See Figs. on Art Paper VII