NON GRAVID HORN CAUSING OBSTRUCTION IN LABOUR

(A Case Report)

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The present case report is concerned with a case of uterus bicornis bicorpus bicollis with single vagina in which labour had been obstructed alternately by the non-gravid horn of the double uterus on the successive pregnancies necessitating the performance of L.S.C.S. on these occasions.

CASE REPORT

Patient aged 36 years was admitted in obstructed labour for more than 48 hours. She was gravida 4, para 3, with first 2 normal deliveries conducted at home. One and a half year ago she had come to the hospital in similar conditions as in the present pregnancy and at that time she was wrongly diagnosed as a case of pregnancy with right sided ovarian cyst obstructing the labour and the L.S.C.S. with ligation of the tubes had been done. She had no antenatal care in the present pregnancy and did not know till late in the pregnancy that she was pregnant as tubal sterilization had been done in the last pregnancy.

On examination, the patient was ill looking toxic, with rapid pulse, high temperature and high B.P. On abdominal examination, uterus was full term with cephalic presentation which was high floating, F.H.S. was rapid and feeble and gut and bladder were distended. On vaginal examination, vagina was hot, cervix was pushed very high in the right fornix, 2/5th dilated and thick; membranes were absent, vertex was high and non-engaged and there was thick meconium. On the left side of the pelvis a firm globular mass of the size of 12 weeks' pregnancy was palpable which was slightly mobile from anteroposterioly but not from side to side and this was obstructing the presenting part.

Again the diagnosis of obstructed labour due to impacted ovarian cyst was made, as the possibility of fibroid was ruled out because of previous diagnosis of ovarian cyst at operation, Immediate L.S.C.S. was undertaken. On opening the abdominal cavity the whole pregnant uterus was shifted to the right side and could not be brought to the centre, so the mass on the left side was explored which turned out to be the non-gravid horn of the uterus bicornis bicollis of the size of 12 weeks' pregnancy with left tube attached to it which had been ligated. The non-gravid horn was pushed to the left side of the abdominal cavity so that gravid uterus could be brought to the centre of the pelvic cavity and the L.S.C.S. was done. There was some difficulty in the separation of bladder from the lower uterine segment. An asplyxiated 7 lb male baby was delivered who was resuscitated. The cervical canal of this side of uterus was separate from the left one. Right tube was sterilized. The postoperative period was uneventful and patient left the hospital on 8th postoperative day.

Discussion

On retrospective study of the present case it was concluded that during the last

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pregnancy, the left horn of the double uterus was pregnant and the non-gravid right horn had caused obstruction of labour and wrongly diagnosed as ovarian cyst at that time. In the present pregnancy the other horn with non-ligated tube had become pregnant and the non-gravid horn was causing the obstruction.

The obstruction by the non-gravid uterus is a relatively rare complication peculiar to patients with uterus bicornis bicollis and uterus bicornis unicollis and is an immediate indication for L.S. C.S. Semmens (1962) has reviewed in detail the overall problems of 56 personal and 500 reported cases of genital tract anomalies out of which 25 personal and 200 reported cases from the literature had uterus bicornis bicollis. Two cases in the personal series and 16 in the reported had the intrapartum complication of incarceration of the non-gravid horn causing obstructed labour. The incidence of congenital anomalies with pregnancy has been reported to be 1 in 954 to 1 in 2,683 pregnancies (Loring, 1973). The incidence of uterus bicornis bicollis is not readily determined from the literature as the abnormality is considered to be quite rare. The presence of vaginal septum is a clue to the presence of uterine anomaly and in its absence the presence of an asymmetrically located cervix in the vagina and excessingly large cervix with or without septum in a nullipara or a duplicate cervix may indicate the presence of uterine anomaly and warrants investigations. Most of the cases of congenital anomalies of uterus are normal obstetrically unless proved otherwise. The two factors of importance are, (i) there must be clinical awareness of the existence of the anomaly and (ii) if the exact nature of the anomaly is known most of the complications of pregnancy can be anticipated and avoided.

Summary

A case of incarceration of non-pregnant uterine horn of a uterus bicornis bicorpus bicollis with single vagina is presented. The complication is very rare and only 18 such cases have been reported in the literature.

References

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2. Loring, T. W.: Am. J. Obst. & Gynec. **15**: 505, 1973.