# UNILATERAL DYSMENORRHOEA

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Laparotomy and laparoscopy are rarely performed in cases of dysmenorrhoea for diagnostic purposes because of their limited significance and rare necessity. But whenever a patient complains of intractable dysmenorrhoea particularly one sided, one has to think in terms of uterine anomaly and pelvic endometriosis and laparoscopy and laparotomy are indicated as the case may be.

## CASE REPORT

A case of unilateral dysmenorrhoea of 10 years duration is presented.

A 25 years old nulliparous woman was admitted in Kilpauk Medical College Hospital, Madras with the complaints of severe abdominal pain, more during the menstrual periods.

The pain starts 2 days prior to the onset of menstrual flow and lasts for about 15 days. The pain was very severe during the flow and the pain incapacitated her very much. The pain used to start in the right lower abdomen and shoot down the right thigh and confine to that side. Pain was associated with nausea and vomiting. During the rest of the time also she used to have aching pain over the right lower abdomen.

She was suffering from the pain since the onset of menarchae which was at the age of 15. She was married for the past 8 years and had not conceived. Her husband had deserted her because she was continuously suffering from the disability. Her cycles were 3/30 regular, moderate.

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Accepted for publication on 24-10-78.

She is a moderately built female with no obvious abnormality. Abdominal examination revealed nothing abnormal. Vaginal examination showed uterus to be retroverted, retroflexed normal in size and freely mobile. No adnexeal mass could be made out. Routine investigations revealed nothing abnormal.

She was posted for laparotomy on 3-5-77 with a view of doing a Gilliam's operation. On opening the abdomen, findings revealed gross abnormalities. There was a nodule like mass about 1" diameter over the right side of the uterus (Fig. 1). This side of the uterus was very much smaller than the left side. The right tube and round ligament were attached to the right horn. The right sided ovary was enlarged and cystic. Right tube and round ligament were short, thin and flimsy. Left tube and ovary were normal. The right sided small horn was excised, along with the tube and ovary. Now it was observed that this small horn was not communicating with the main half of the uterus, or cervix or vagina. The left horn was almost of normal size of uterus. The right horn on opening was found to have thick altered blood. A diagnosis of Uterus Bicornis Unicolis with a rudimentary horn was made. Postoperative period was uneventful.

### Histo-pathology Report

1. Ovary: Shows Corpora albicantes and follicular cysts.

2. Uterus: Structure of uterus with endometrium. Endometrium in proliferative phase.

3. Tube: Structure of tube.

**Follow-up:** The patient is free from pain from the date of operation. The patient conceived soon after surgery and the antenatal period was uneventful and she delivered an alive female baby on 28-7-78.

*Summary*

A case of unilateral dysmenorrhoea of long duration due to uterine anomaly is presented. After a small operative procedure the patient was relieved of the dysmenorrhoea and conceived. In rare cases of unilateral dysmenorrhoea, endometriosis and congenital uterine anomalies such as bicornuate uterus with unequal development of two horns, must be excluded (Bender, 1977).

*Conclusion*

Though the uterine anamoly is a rare entity, it should be thought of in a case of unrelieved dysmenorrhoea. Laparoscopy or whenever indicated laparotomy will be of immense value in selected cases of dysmenorrhoea particularly of the unilateral type.

*References*

1. Bender, S.: J.l. of App. Medicine. **3: 939,** 1977.

*See Fig. on Art Paper III*