FULLTERM BINOVULAR TWIN PREGNANCY IN BICORNATE UTERUS

(A Case Report)

by

USHA R. SHARMA,* M.S.

and

P. L. GUPTA,** M.S.

Congenital anomalies of the female genital tract have been a topic of interest to gynaecologists and obstetricians. These malformations may be responsible for infertility and unusual and difficult obstetrical problems during pregnancy and labour.

Polak (1923) reported that a single pregnancy is 7 times more common than double in bicornuate uterus. Broady (1954), Dorgen and Clark (1956) and Brown (1956) reported cases of twin pregnancy in each of the well developed horn of uterus and delivered alive foetuses vaginally at term. Zetvoudakis *et al,* (1976) reported an unusual case of twin pregnancy in bicornuate uterus detected during medical termination of pregnancy and there was small pinpoint communication between the two horns. From India Khandwala (1956) reported a case of twin pregnancy in a bicornuate uterus.

Here similar unusual case of binovular twin pregnancy in bicornuate uterus is presented with the specific interest that there were well developetd uterine horns communicating with a single cervix and vagina, and the woman delivered 2 alive babies at full term.

*Lecturer.

**Reader.

Department of Obstetrics and Gynaecology, J.L.N. Medical College and Hospital, Ajmer 305 001, Rajasthan INDIA.

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CASE REPORT

Mrs. A. K., 26 years old woman was admitted on February 20, 1977 in J.L.N. Zanana Hospital, Ajmer (Rajasthan), with amenorrhoea of 7 months duration (L.M.P. not known), yellow colouration of urine and sclera with loss of appetite for last 20 days and distension of abdomen for last 7 days.

The age of menarche was 14 years Menstrual cycles were painless, regular at intervals of 28-30 days and lasting for 5-6 days with normal bloodloss.

Obstetrical history revealed that she was 7th gravida. She delivered 5 alive premature babies of 7 months gestation but all died immediately after birth. Last full term normal delivery was 2½ years back and the male child is alive.

On general examination she was found averagely built and nourished, mildly anaemic, sclera deeply yellow, liver enlarged and tender palpable 3 fingers below costal margin. Other systems were normal.

On abdominal examination two separate oval shaped lumps were felt on both sides. Foetal heart sounds were present on left side but not clearly heard on rlght side.

On vaginal examination closed single cervical os was felt. Investigations: Hb 9 gm%. Urine sugar and albumin were absent but bile salts and pigments were present; Bleeding time and clotting time were within normal limit; ECG Normal. Liver function tests: Serum bilirubin

3.2 mg%, prothrombin time 31 seconds, thymol turbidity 6 units, Van den Bergh immediate direct positive.

Provisional diagnosis of twin pregnancy in bicornuate uterus with infective hepatitis was made.

She was treated conservatively for infective hepatitis and responded well. She was discharged from the hospital on request after complete recovery from jaundice. On 7-4-1977 she delivered alive premature female child at home, and after 15 minutes placenta and membranes were completely expelled. Then she was brought to this hospital and admitted. Obstetrical examination revealed uterus of 34 weeks size lying more on right side, foetal heart sounds were present and uterus was acting mildly.

On vaginal examination cervical os admitted 2 fingers, was partially taken up and there was tense bag of membrane. Induction of labour was done by artificial rupture of membranes, syntocinon 2.5 units in 500 ml of 5% glucose (G.D.W.). Patient delivered an alive asphyxiated female child after 11 hours of the first delivery at home. There was no third stage complication. Both premature newborns died after 4 days. Patient was discharged on 6th day and was advised to attend post-natal clinic for hysterosalpingography but she never turned up.

After about 4 months she again came to the hospital and on examination was found pregnant. This time the diagnosis of twin pregnancy in bicornuate uterus was made. She was given hormonal treatment and attended antenatal clinic regularly till 36 weeks of gestation. Then she was admitted and kept under constant supervision. She delivered full term alive binovular twins (one male and one female) without any complication.

She wanted sterilization, so under general anaesthesia laparotomy by subumbilical midline incision was done. There were two well developed uterine horns with one ovary and one fallopian tube on each horn (Fig. 1). Tubectomy was done by modified Pomeroy's technique. Abdomen was closed in layers. Postoperative period was uneventful and the patient was discharged on 7th day in good condition with two live children.

Discussion

This case was not diagnosed during the previous 5 conceptions. Conceptions must have occurred in one or the other horn in these 5 pregnancies.

This case of bilateral pregnancy in bicornuate uterus is interesting because during two successive pregnancies bilateral pregnancies occurred.

Khandwala (1956) reported a case of twin pregnancy in a bicornuate uterus in which one horn contained a normal foetus and the other an anencephalic monster presenting as breech.

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See Fig. on Art Paper IV