TORSION OF THE GRAVID HORN OF BICORNUATE UTERUS

(A Case Report)

by

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Introduction

The anatomical disposition of the uterus is such that despite its free mobility in all the axis, its torsion is extremely rare because of the two strong transverse ligaments fixing it to the lateral walls of the pelvis. We came across a patient undergoing torsion of gravid horn of the bicornuate uterus as late as 32 weeks of gestation and we thought it worth reporting.

CASE REPORT

Mrs. B.D. aged 26 years, 2nd gravida was admitted in labour room of Patna Medical College Hospital on 7th April, 1977 with the history of 32 weeks' amenorrhea and acute abdominal pain associated with nausea, vomiting and abdominal distension for 6-8 hours.

Her first child was still born at term for which no cause was ascertained. Her previous menstrual cycles were regular and last menstrual period was in early August.

General examination revealed her to be ill-looking, apprehensive, moderately pale with pulse 100/m, and B.P. 110/70, mm of Hg. Tongue was clear and moist. Systemic examination did not reveal any abnormality.

On abdominal examination there was generalised distention all over. Bowel sounds were heard. Uterus was 32 weeks' size with cephalic presentation in left occipito-anterior position. Head was not engaged. Foetal heart rate was 142/minute, regular. There were no palpable uterine contractions.

On pelvic examination, the patient was not found to be in labour. There was no abnormal discharge. A tentative diagnosis of appendicicitis or any other surgical complication was thought of, though accidental haemorrhage was also kept in mind. Therefore, a conservative line of treatment was adopted by sedation, I.V. fluid and Ryles' tube aspiration.

A surgeon was also consulted who advised to continue this conservative treatment.

Unfortunately, the general condition of the patient deteriorated. Uterus became tender on palpation. The pallor increased. The foetal heart sound became inaudible. Therefore, laparotomy was undertaken.

On opening the abdomen, the ecchymosed uterus was visualised. On further exploration it was discovered that it was a bicornuate uterus. The gravid horn of 34/weeks' size had undergone torsion of 180°. The other horn was normal in size and attached to the gravid one by a thick broad fibrous band. A deeply asphyxiated baby was taken out by incising the lower end of the uterus. Placenta was spontaneously delivered, after which the torsion was corrected. On exposing the cavity of the pregnant horn it was seen to communicate with the non-gravid horn through a tiny hole in the thick fibrous band. The cavity of non-gravid

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uterus was continuing with the single cervical canal. This gravid horn was removed with its fallopian tube and ovary.

Post-operative period was uneventful and patient was discharged on 12th post-operative day.

Discussion

This condition is not as uncommon in gravid horn of bicornuate uterus or at times even in unicornuate pregnant uterus. Shah *et al* (1968) and Jungullwalla and Bandi (1971) have reported torsion of the gravid horn of a bicornuate uterus.

The condition invariably presents with acute abdomen with or without abdominal pain during the preceding few days and is likely to be mistaken from the commoner condition for the particular period of gestation. i.e.. ruptured ectopic in early pregnancy, torsion of the ovarion tumour in mid-pregnancy and abruptio placentae in 2nd and 3rd trimesters of pregnancy. Marked tenderness over the uterine area, absent or feeble foetal heart sounds and absence of vaginal bleeding should arouse the suspision of the condition if abruptio placentae has been ruled out.

The foetus should be taken out as early as possible and more so when the foetal heart sound is present, even when one has to make an incision on the posterior surface. If it is normally developed uterus, previous obstetric history is bad, only the repair of the uterine incision is done like that in caesarean section after securing haemostasis.

However, when the uterus is left behind its vascularity must be properly assessed.

Hysterectomy is advised when there is doubt about the viability of the uterine musculature or the patient has completed her family, and hemihysterectomy or removal of the gravid horn of the bicornuate uterus, when the other horn is functioning and the patient is young or has not completed her family, as in the present case.

References

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