# DOUBLE PREGNANCY IN A UTERUS DUPLEX UNICOLLIS

## (A Case Report)

by

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The literature on the subject of double uterus is very extensive. The term 'double uterus' is being applied to any condition resulting from the failure of complete fusion of the Mullerian ducts. Thus it includes separate uterus, biocornuate uterus, uterus duplex unicollis and true uterus didelphys i.e. double uterus, double cervix and double vagina. Each uterus has only one tube and there are only two ovaries. This case deals with fusion below the internal os but above the external os.

### CASE REPORT

A 22 years old fourth para was brought to the hospital on 1-8-1981 at 11.00 A.M. for labour pains. She had delivered a male infant with normal expulation of placenta at 1.00 P.M. on same day at home. Dai (A.N.M.) was suspecting second infant (twin pregnancy) so referred her to hospital for further management.

#### Examination

She was a well built, fairly nourished woman. Abominally uterus was enlarged upto costal arch, lying only on left side of midline. Foetal parts were palpable and foetal heart sounds were audible. Foetus was with vertex presentation and head was floating. Vaginal examination showed normal vagina, with cervix admitting only one finger eventhough she had delivered before ten hours. Cervix was looking like dividing into two branches left and right, admitting one finger on either side. Patient had low grade pain with no uterine contractions.

#### Management

X-ray abdomen was taken, showed position of second foetus, skull was high above ischial spines. As head was high with normal shape and patient had weak pains, syntocinon 5 I.U. in 540 ml. 5% glucose was started as a slow intravenous drip in three hours. There was no progress of labour, head was floating and cervix was admitting one finger only. Again intravenous drip of 5% glucose with 10 I.U. of syntocinon was given slowly and meanwhile emergency caesarian section was planned. There was no progress after three hours of second drip.

Abdomen was opened by infraumbilical midline vertical incision. Peritoneum was opened and there were two complete separate uterii. Foetus was present in left uterus and right was enlarged upto umbilicus. Left uterus was opened by lower transverse incision and a female foetus was delivered with placenta. On closing uterus in layers, anatomy of uterii was studied. There were two separate uterii upto cervix with one fallopian tube and ovary on their outer side. Abdomen was closed in layers. First home delivered infant was 2.2 kg. weight and second female infant was of 1.9 kg. weight looked normal and mature.

On fourth day of delivery both infants developed jaundice. On investigations, mother was Rh negative blood group while both infants,

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father and first 6 years old child were Rh positive. Treatment was given to both infants. Female infant expired on 6th day. Male infant became normal. On tenth day both mother and male infant were discharged.

Before discharging the patient, anatomy of vagina and cervix was studied again. There was one vagina and externally one cervix visible (Fig. 1). There was 1 os externa and 2 os interna; cervical canal was branching into two, shown by position of dilators (Fig. 2). Cervix was separate in the midline and was connected separately to uterus on each side. Hysterosalpingography was done which shows double uterus (Fig. 3).

*See Figs. on Art Paper II*