Double Uterus with Obstructed Hemivagina and Ipsilateral Renal Agenesis – A Case Report

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The unique clinical syndrome consisting of double uterus, obstruction of hemivagina and ipsilateral renal agenesis is rare. The renal agenesis on the side of obstructed vagina associated with a double uterus and double cervix is suggestive of an embryologic arrest at eight weeks of pregnancy that simultaneously affects the mullerian and metanephric ducts. The exact cause is not known. Patients may present with paravaginal mass and symptoms of severe dysmenorrhoea and lower abdominal pain with regular menses.

Case Report

Miss M, 17 years old girl presented with severe dysmenorrhoea and pain in right lumbar region since one year. Her menstrual cycle was regular, 6-7/28-30 days with average loss. There was no history of urinary or bowel disturbance. On examination, she was thin built with mild pallor. Systemic examination was normal. On per rectal examination uterus was small in size with a mass felt on right side 10 x 8 cms. cystic to firm in consistency. Investigations done were Hb 11.7 gm%. Urine R/E NAD, S. Creatinine 0.8mg%. USG showed right renal agenesis with hypertrophy of left kidney. Uterus was bulky with two hypoechoic masses 5.2 x 2.9 cms and 3.8 x 4.7 cms seen adjacent to uterus with mixed echotexture. IVP confirmed absent right kidney. Patient was taken up for laparotomy under G.A. with provisional diagnosis of right ovarian tumour.

Operative findings:- Flimsy adhesions of omentum with peritoneum present. Small left ovarian cyst 2 x 3 cms seen. On right side, there was a chocolate cyst 5 x 6 cms in diameter, adherent to the peritoneum. Right fallopian tube was enlarged with oedematous filmbrae and deposits of external endometriosis. Uterus was diadelphys with complete obstruction of right hemivagina. Right sided hematometra and hematosalphinx were seen. Left tube was normal. Left ovarian cystectomy was done. Right sided choclate cyst drained. Capsule removed and ovary reconstructed.

Intraoperative per vaginal drainage of right hematometra was attempted but was not possible. Right hematometric uterus and cervix removed after clamping and cutting and ligating round ligament, uterine artery, Mackenrodt's and uterosacral ligaments. Fibrous band present between two uteri was cut and ligated. Reperitonization done and stump of fibrous band sutured with right round ligament stump. Left round ligament plicated.

Histopathology: Early secretory endometrium with hematometra with mild chronic endocervicitis. Fibrous band showed fibroconnective tissue with few blood vessels.

Post operatively, patient was managed with IV fluids, antibiotics and analgesics. Suture removal done on 7th POD and the patient discharged in satisfactory condition with advice to take danazol for six months.

Patients came for follow up at six weeks, six months and one year after surgery with no complaints.