

# Unicornuate Uterus and Non-communicating Uterine Horn Containing Functional Endometrium with Retrograde Menstruation and Ipsilateral Renal Agenesis – A Case Report

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Unicornuate uterus and non-communicating uterine horn containing functional endometrium with retrograde menstruation and ipsilateral renal agenesis, is a rare congenital anomaly that is rarely identified prior to menarche. Patients with this anomaly commonly present with symptomatic unilateral hematometra following the onset of menses.

A nulliparous, 15 year girl presented to the Mahila Chikitsalaya, Sanganeri Gate, Jaipur on 13-12-99 with complaints of severe abdominal pain during periods since 1½ years now continuous mild pain for 6 months. Menarche was at 13 years of age, initially pain was mild to moderate, after 6-7 months, severity increased and was associated with vomiting and diarrhea. Patient was not even able to sit properly. Initially pain decreased in intensity by antispasmodics, later on drugs also became ineffective. She consulted general practitioner, who advised ultrasonography (USG) and treated with antitubercular drugs (ATT) for 2 months with no relief. Then she was referred to us.

On examination-abdomen was non tender and no lump felt.

USG showed (6 month back) normal uterus and adnexa with absent left kidney at normal site and suspected ectopic left kidney in pelvis. Multiple cystic areas were seen in pelvis, like ovarian cyst or ? tubercular peritonitis. After USG she was advised diagnostic laparoscopy and/or CT scan but she refused for both at that time.

CT scan showed that left kidney was absent, uterus bicornuate with right horn communicating with cervix. Left horn was at pelvic brim and not

communicating with cervix but communicating with a tubular structure (? Fallopian tube). Multiple haemorrhagic cystic masses seen in pelvis.

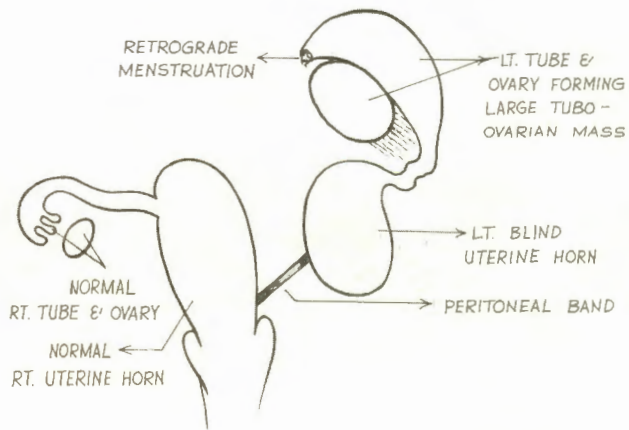
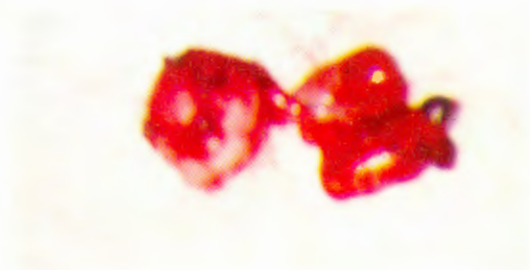


Illustration 1: A non-communicating left uterine horn with functional endometrium that contains menstrual blood (hematometra). Tube is dilated and retort shaped (hematosalpinx). Large tubo-ovarian mass was formed because of retrograde menstruation. It should be noted that left tube and ovary is higher up (at the level of pelvic brim).



Photograph 1



Photograph 2

**Operation notes:** On per vaginum examination under general anesthesia – vagina and cervix were normal with a firm mass felt in the left fornix of 12 weeks size and fullness in posterior fornix. Uterus was deviated to right. At laparotomy, large flimsy bands of adhesions looking like separate cysts were present in whole pelvis below the pelvic brim which were separated. Thin, watery brownish fluid was present in the pelvis. There was well developed unicornuate uterus communicating with

normal tube and normal cervix. Normal ovary was present on right side. There was firm, enlarged mass (15 x 10cm) present on the left side at the pelvic brim, round and thickened, which was communicating with the left tube, which was elongated, thickened, dilated and tortuous in its whole length. Fimbriae were thickened, swollen and cystic with blood coming out through it. The left mass (cornua) was joined through a peritoneal fold to right uterus. Left ovary was enlarged, congested and forming a tubo ovarian mass. (Illustration I). The left blind uterus which was not communicating to cervix was removed along with tube and ovary (Photograph 1). Peritoneal lavage was done with normal saline and abdomen closed in layers. Post-operative recovery was uneventful.

Cut section of the mass showed a cavity, filled with chocolate coloured thick fluid, communicating with fallopian tube (Photograph 2).

Patient had her normal periods on fourth post-operative day which was painless and her abdominal pain was also relieved.