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Uterine Didelphys, One with Term Pregnancy and the Second was Prolapsing: A Rare Case Report

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KEYWORDS

Uterus Didelphys, term pregnancy, Prolapse, Caesarean section

ABSTRACT:

Uterus Didelphys is a rare congenital abnormality of uterus in which uterus is present as a double organ when the mullerian ducts fail to occur .As a result there occurs a double uterus with two separate cervices and often a double vagina as well. We present a case of 24 years Primipara lady who has right gravid uterus and during her third trimester she has prolapse of non-gravid uterus .Which reduced gradually but spontaneously with manipulation and dressing she delivered a male child by caesarean section due to oligohydramnios with shoulder presentation during current pregnancy.

1. Introduction

Congenital uterine anomalies arise from abnormal Mullerian duct formation, fusion, and reabsorption during fetal life. Complete fusion failure of two Mullerian tubes results in uterine didelphys. Anatomically uterine didelphys has two uteri, two cervices, and a single or double vagina [1, 2].

The true prevalence of malformation remains uncertain as many of them are asymptomatic and are not picked up. Uterine malformation has been reported in up to 7% of the general population, 7% of the infertile population, and 18% of those with recurrent pregnancy loss [3].

The American Society for Reproductive Medicine (ASRM) created the most widely known classification system for Mullerian duct anomalies in 1988; however, it is almost entirely limited to describing uterine abnormalities. A new classification in 2013 was developed by the European Society of Human Reproduction and Embryology, and the European Society for Gynecological Endoscopy. Identifying the exact nature of a patient's anomaly is crucial to understanding the suspected effect on reproductive health [4].

The presence of a uterine defect increases the risk of obstetric complications, indicating the need for frequent checks during pregnancy [5].

A view by Grimbizis demonstrated the incidence of MDAs in infertile patients (3.4%) similar to that of the general population and/or fertile women (4.3%) and they concluded that MDAs may not harm fertility. The women with didelphys uteri have multiple gestations with twins or triplets and exhibit the ability to be pregnant resulting in a healthy growth of a fetus in either one of the uteri. A different, large retrospective study done by Raga et al. found the incidence of these anomalies to be significantly higher in infertile women suggesting a link between infertility and the MDA [6]. Our case does not fall into any one of the two classifications according to the new classification of Herlyn Werner–Wunderlich Syndrome (HWWS)[7].

2. Objectives

In the present study, documents the case of a woman who carried a live pregnancy to term while the other prolapsed.

3. Methods

CASE REPORT

24 years primigravida was admitted through our OPD at 30 weeks of gestation with complaints of something coming out of the vagina for 4 days. On examination, there was a prolapse of the non-pregnant uterus and cervix. She was admitted to our antenatal ward and the prolapse gradually reduced with dressing and manipulation. Ultrasound shows a normal fetal biophysical profile (body movements, muscle tone, breathing movements, amniotic fluid, and heartbeat). She was discharged with advice to commit to regular

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antenatal follow-up. She came to OPD at a gestational age of 38 weeks for follow-up. On abdominal examination, the fetus was in shoulder presentation. On per vaginal examination, the cervix was effaced; os was closed, and not engaged. A USG was done for FBPP which showed a single pregnancy of average gestational age of 37 weeks 3 days with an approximate weight of 2.9 kg with shoulder presentation and oligohydramnios. She was planned for elective cesarean section. LSCS under spinal anesthesia and a male child was delivered. On examination, there was another uterus right to the gravid uterus with the right fallopian tube and ovary attached [Figure 2]. Then uterus was closed in double layers and the abdomen was closed in layers after maintaining proper hemostasis. We did tubal ligation upon the patient's request. The postoperative period was uneventful and she was discharged on the 10th postoperative day with advice of follow-up.

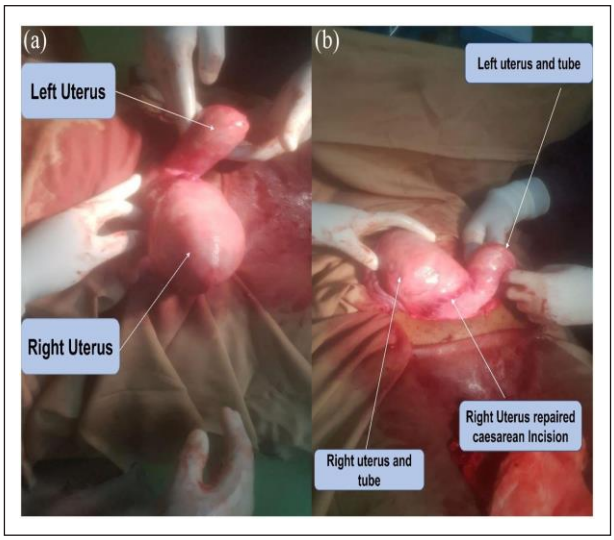

Figure1. Ultrasound shows double uterus and cervixes

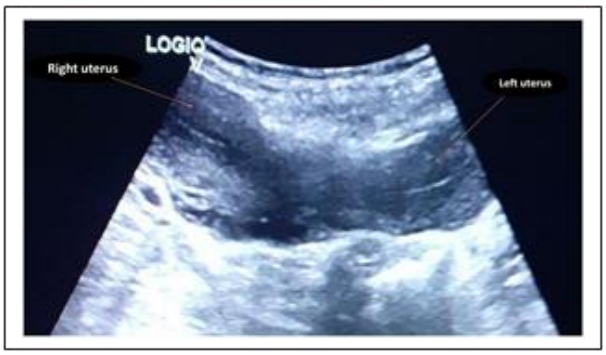

Figure2. Intra-operative view of the double uterus; An anterior view of the double uterus, with a repaired cesarean incision of the right uterus

4. Discussion

Some reported live birth in women with didelphys is less than half with about 1 in 3 pregnancies ending up in abortion; about half in premature deliveries, about 1 in 5 reaching term, and others reported good pregnancy results with good management.

This patient had spontaneous conceptions and it carried to complete pregnancy, the reasons might be the level of development and capacity of the uterus [8].

In some cases, surgical delivery has been perceived as the safest method of delivery for Mullerian abnormalities, the reproductive suspected worse than that of a normal uterus but better than other uterine anomalies [9, 10].

However, a retrospective study done by Zhang et al. demonstrated that patients with didelphys uterus required infertility treatments more frequently than those with other anomalies [11, 6]. Some reviews stated the double uterus has a poor maternal outcome with a 20 to 30% chance of carrying pregnancy to term [12, 13].

In contrast, Rezai et al. suggested that the didelphys uterus is not an indication for cesarean delivery unless the vaginal septum is thick and inelastic resulting in an increased risk for vaginal dystocia [14]. Our patient had two uteri, one with term pregnancy and the second was prolapsing.

Unless indicated, uterus didelphys by itself is not an indication for Caesarean delivery, although its presence increases Caesarean Section rates [15]. Nowadays the uterus didelphys is more occurrences which correspond to a meta-analysis of 25 studies involving more than160, 000 women, of which 3766 with congenital uterine anomalies [16].

Based on the review of the literature we think that CS and uterus didelphys a cause, but not absolute indication for CS. However, uterus didelphys and normal deliveries had been reported even after CS [17]. Although vaginal deliveries are reported in patients with uterine didelphys, we believe that surgical delivery is a safer method for this Mullerian anomaly associated with complications and malposition [18, 19, and 20].

Our case is a unique and special one, the uterine anomaly with prolapse was diagnosed after conception and an antenatal ultrasound scan during the third

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trimester; she had a term pregnancy without any antenatal complications.

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