

Successful Pregnancy Outcome and Uneventful Vaginal Hysterectomy in Uterine Didelyphys

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Abstract: *Congenital malformations in a female genital are most commonly diagnosed in the reproductive period. This is a case report of uterine didelphys, which was diagnosed, in post-menopausal period of the women with general prolapse who came to our institute for hysterectomy with successful obstetric outcome.*

Keywords: General Prolapse, Uterine Didelyphys, Vaginal Hysterectomy

1. Introduction

Congenital malformations of the female genital tract have its representation in less than 15% of women. Most of who presents with menstrual disorders, dysmenorrhoea or with bad reproductive outcomes. Women who have double uterus have more obstetric complications in the form of miscarriage and premature births and mal presentations.

2. Case Report

Mrs. T. is a 70 year old woman who had presented with mass per vagina since 7 months. She had no symptoms of bowel or bladder disturbances. She had attained menopause 25 year back. She had eight normal deliveries at term, average sized babies with last child birth 32 year back. Interval between the pregnancies was 2.3 years. Other past, personal and family history was not significant. She had not undergone sterilization. She was thin built. Her respiratory, cardiovascular and abdominal examinations were within normal limits. Local examination revealed a mass of III degree descent of uterus and vagina (cystocele, enterocele and rectocele). Septum of 1 cm width was seen extending from anterior vaginal wall to the posterior vaginal wall up to the fourchette. On bimanual examinations, uterus was found to be atrophic and fornices were free. Diagnosis of general prolapse was made and she was prepared for vaginal hysterectomy with pelvic floor repair. Cytology was normal. Ultrasonography revealed uterus and ovaries atrophic and no other uterine abnormalities were detected.

3. Intraoperative Findings

Vaginal septum could be visualized and was cut. Difficulty was noted in opening of the Uterovesical pouch anteriorly and pouch of Douglas posteriorly. Two cervixes were seen and dilators were passed. Anteriorly a septum was noted extending from the posterior aspect of bladder up to the pouch of douglas which was cut and ligated and opened. Cervix was dissected in the middle taking precautions to prevent bladder and bowel injuries. Anteriorly bladder was pushed up and the uterovesical fold of peritoneum cut and

fundus of both the uteri seen. After this the hysterectomy was completed with regular steps. On gross examination, one uterus had a well-defined endometrial cavity and in the other a poorly defined endometrial cavity was noted (Fig1). Post-operative period was uneventful. Patient was discharged on the 8th post-operative day, with stable vitals.

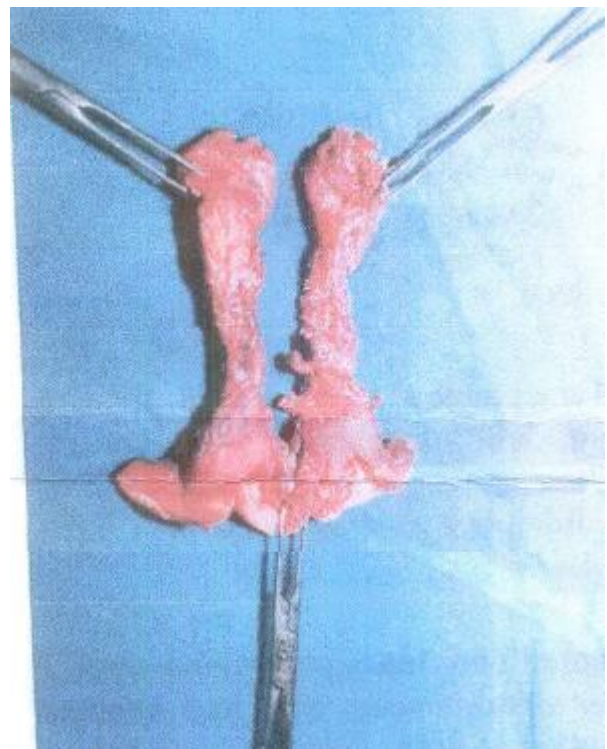


Figure 1: Double uterus with two separate cervixes

4. Discussion

Uterus didelphys (which is also known as uterus didelphis) represents a uterine malformation where in the uterus is presented as a paired organ due to the embryo genetic fusion of the mullerian ducts failed.

The uterus normally is formed during embryogenesis by the fusion of the two mullerian ducts, this process of mullerian

ducts fusion form a single uterine body but failure of this process leads to formation of double müllerian systems. A didelphic uterus will have a double cervix and is usually associated with a double vagina. Each of the two uterus has a single horn which is linked to the ipsilateral fallopian tube which then faces its ovary. Causes for the failure to fuse is not known. The associated defect is mainly noted in the vagina, the renal system and less commonly, the skeleton.

The malformation is less common than the other malformations: arcuate uterus, septate uterus and bicornuate uterus. It occurs in 1/3000 women. Double uterus is rare and many a times remains undiagnosed. According to an estimate, uterine abnormalities occur in 4% of women who have normal pregnancies, and 5% with double uterus. The percentage of women with a double uterus is likely higher in women with a history of miscarriage or premature birth.

Most women with this condition remain asymptomatic and unaware of having a double uterus. However, a study by Heinonen showed that certain conditions are more common. In his study of 26 women with a double uterus gynaecological complaints included dysmenorrhea and dyspareunia. All patients displayed a double vagina. The foetal survival rate in 18 patients who delivered was 67.5%. Breech presentation was present in 43% and premature delivery common (21%).

Pelvic examinations will typically reveal a double vagina and a double cervix. Investigations techniques to diagnosis the uterine structure are transvaginal USG and sonohysterography, hysterosalpingography, MRI and hysteroscopy. More recently 3 – D USG has been advocated as an excellent non-invasive method to evaluate uterine malformations.

Patients with a double uterus may need a special attention during their pregnancy as premature births and malpresentations are commonly associated with this. Caesarian section was noted to be performed in 82% of patients reported by Heinonen. A specific association of uterus didelphys, unilateral hematocolpos and ipsilateral renal agenesis has been described.

A number of twin gestations have occurred where each uterus carried its pregnancy separately. It is possible that the deliveries occur at different times, thus the delivery interval could be days or even weeks rarely. A rare case of a woman from UK with a double uterus gave birth to triplets in 2006. Review of literature showed birth of viable triplets in a woman with a double uterus (Hannah Kersey, of Northam in Devon). It is estimated that the possibility of such a birth is about 1 in 25 million. A triplet pregnancy in a woman with uterus didelphys was reported from Israel in 1981; one baby died in utero, and of the remaining babies, one was delivered at 27 weeks gestation and the other 72 days later.

Treatment is indicated only when this double uterus causes symptoms or complications, such as dysmenorrhea, pelvic pain or repeated miscarriages.

5. Conclusion

Some women have a double uterus and not diagnosed even in pregnancy and childbirth. Similarly in our case report also, not had any obstetric problems or complications, and had uneventful vaginal hysterectomy.

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