

Pregnancy In Non-Communicating Rudimentary Horn of Uterus – A Rare Case Report

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Type of Publication: Case Report

Conflicts of Interest: Nil

Abstract

Aims and Objectives: To report a case of pregnancy in non-communicating rudimentary horn of uterus in a grand multi.

Materials and Methods: A 32-year-old grand multi G6P5L3D2 with 24 weeks POG came to hospital with complaints of absent fetal movements. On examination it was found to be intra uterine fetal death, confirmed by ultrasound. Planned for termination in multiple ways like tab.misoprostol 200mcg 6th hourly followed by Inj. Oxytocin but none of them worked. Finally, case was posted for hysterotomy.

Results: Case was posted for hysterectomy. Intra operatively – On opening LUS, uterine cavity was found to be empty. There was a non-communicating rudimentary horn noted near the right cornua of uterus. On incision, there was a single dead female fetus weighing about 650grams. Placenta and membranes delivered intoto measuring about 150grams. B/l tubes and ovaries – healthy. Incision on horn and LUS

incision were closed with vicryl-1. Procedure uneventful.

Discussion: This case is a Mullerian duct anomaly wherein pregnancy was implanted in a non-communicating rudimentary horn of uterus in an asymptomatic grand multi, who previously delivered 5 babies vaginally. Sensitivity of sonography decreases with advancing gestational age and there are no clinical criteria to diagnose. Rupture of rudimentary horn with severe bleeding is the most possible life threatening complication. Time of rupture varies from 5 to 35 weeks period of gestation, depending on the musculature of horn and ability to hypertrophy. Live birth after hysterotomy or caesarean delivery is extremely rare with complications like fetal growth restriction and prematurity.

Conclusion: Though there is a major advancement in field of ultrasound and other diagnostic modalities, prenatal diagnosis is always elusive and laparotomy is only considered to be definitive diagnosis. Rupture being

the most fatal complication- early diagnosis, timely resuscitation, laparotomy and blood transfusion are the steps of management.

Keywords: Non Communicating Rudimentary Horn, Mullerian Duct Anomaly, Hysterotomy, Miscarriage.

Introduction

Incidence of mullerian anomalies is difficult to assess but accounts for about 0.5% of general population. Here is to report a rare case of mullerian duct anomaly with non-communicating rudimentary horn. A grand multi with 24 weeks period of gestation in the non communicating rudimentary horn of uterus, outcomes of the above case are discussed.

Materials and Methods

A 32 year old grand multi G6P5L3D2 with 24 weeks period of gestation attended the OPD of OBGYN, Government medical college, Vizianagaram with complaints of absent fetal movements. On examination fetal heart sounds are absent which was confirmed by ultrasound. After intra uterine fetal death was confirmed, termination was tried by several methods. Firstly, induced with Tab. MISOPROSTOL 25mcg per vaginally for 6 doses every 4-6hourly. Later augmented with Oxytocin drip but none of them worked. Case was finally posted for hysterotomy.

Results and Discussion

On opening, uterus was enlarged on right side, mimicking the appearance of an ovarian cyst which was confirmed to be the rudimentary horn of uterus near the right cornua of uterus. On opening the lower uterine segment, uterine cavity was found to be empty. Upon incision on the rudimentary horn of uterus, single dead female fetus weighing about 650grams was found. Placenta and membranes measured about 150grams delivered intoto. Bilateral tubes and ovaries are healthy

and are anatomically normal in position. Incision on the horn and the lower segment of uterus were closed. Hemostasis secured and procedure uneventful.



Fig. 1: uterus with enlarged non communicating rudimentary horn on right side.



Fig. 2: Incision on lower uterine segment revealing empty uterine cavity with no products of conception.



Fig. 3: Fetus and placenta obtained on giving incision over the rudimentary horn

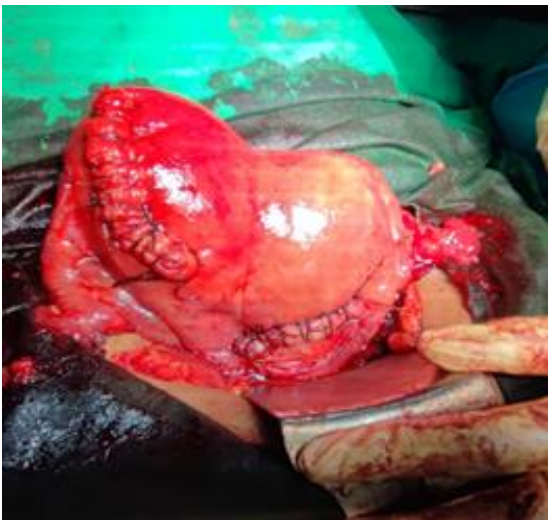


Fig. 4: Both incisions closed. Bilateral tubes and ovaries are healthy. Normal in position.

This is a mullerian duct anomaly, classified as U4 of ESHRE classification, HEMI UTERUS WITH NON COMMUNICATING RUDIMENTARY HORN where in the pregnancy was implanted and reached 24 weeks of gestation in a woman who was a grand multi with previous 5 normal vaginal births. Sensitivity of sonography decreases with advancing gestational age and there are no clinical criteria to diagnose the condition. Rupture of rudimentary horn with severe bleeding is the most possible life threatening complication. Time of rupture varies from 5th to 35th

week of gestation depending on the musculature of horn and the ability to hypertrophy. Live birth after cesarean delivery or hysterotomy is extremely rare with complications like severe fetal growth restriction and prematurity.

Conclusion

Though there is major advancement in the field of ultrasound and other diagnostic modalities, prenatal diagnosis of pregnancy in non-communicating uterine horn is always elusive and laparotomy is only considered to get the definitive diagnosis. Rupture of horn being the most fatal complication- early diagnosis, timely resuscitation, laparotomy and blood transfusion are the steps of management.

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