International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Sagar A et al. Int J Reprod Contracept Obstet Gynecol. 2024 Feb;13(2):444-445
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20240151

Case Report

Dilemma in diagnosis of pregnancy in didelphys uterus: a original case report

Amrita Sagar*, Neeta Sagar, Kusum Dogra

Department of Obstetrics and Gynaecology, Jag Pravesh Chandra Hospital, Shastri-park, New Delhi, India

Received: 06 November 2023
Accepted: 08 January 2024

***Correspondence:**
Dr. Amrita Sagar,
E-mail: dr.amritasagar@gmail.com

ABSTRACT

Uterine didelphys is a congenital defect of female genital system that arises from abnormal embryological development of mullerian ducts. A 30-year-old female G4P3L3A0 at 9 weeks POG with uneventful previous three normal term delivery presented to gynae OPD of JPCH for medical termination of pregnancy and tubal ligation. On per speculum examination, cervix was found to be healthy and on per vaginal examination the uterus was parous size. Right adnexa were free and non-tender but left adnexal mass 4´4 cm felt which was non tender. USG findings was suggestive of live left ectopic pregnancy of 8wks with no free fluid. Patient underwent laparotomy. Per-op findings-two separate uterus with right fallopian tube attached to right uterus and left fallopian tube attached to left uterus. Left uterus was enlarged to 8 weeks. Right uterus was normal in size. Both right and left ovaries were normal. Patient wanted MTP with ligation, suction and evacuation were performed. B/L tubal ligation was done by modified Pomeroy's method. The postoperative period was uneventful and on day -8 stitch was removed.

Keywords: Uterine didelphys, Mullerian anomalies, Pomeroy's method

INTRODUCTION

Uterine didelphys is a congenital defect of female genital system that arises from abnormal embryological development of mullerian ducts. Uterus didelphys is associated with adverse pregnancy outcomes such as recurrent miscarriages, preterm deliveries, low birth weight babies and fetal malpresentation.[1]

CASE REPORT

A 30-year-old female G4P3L3A0 at 9 weeks POG with uneventful previous three normal term delivery presented to gyne OPD of JPCH for medical termination of pregnancy and tubal ligation. On per speculum examination, cervix was found to be healthy and on per vaginal examination, uterus was parous size. Right adnexa was free and non-tender but left adnexal mass 4´4 cm felt which was non tender. There was no cervical motion tenderness. On GPE, PR-88/min BP-120/80, no pallor, no icterus. She was advised an USG which was suggestive of single intrauterine pregnancy of 8 weeks. B/L adnexa was normal. As USG findings were not matching with the clinical findings, she was advised USG again which was suggestive of live left ectopic pregnancy of 8 weeks with no free fluid. So patient was prepared for laparotomy. Per-op findings-two separate uterus with right fallopian tube attached to right uterus and left fallopian tube attached to left uterus. Left uterus was enlarged to 8 weeks. Right uterus was normal in size. Both right and left ovaries were normal. As patient wanted MTP with ligation, decisionfor suction and evacuation was taken. Patient was put in lithotomy position.

Examination under anesthesia showed one cervix divided into two. As pregnancywas in left uterus dilator was passed in left cervix but due to distorted anatomy iatrogenic perforation occurred. Vaginal suction and evacuation was abandoned and decision was taken for evacuation of products of conception through uterus.

One cm incision given on body of uterus and suction evacuation done by Karman's cannula no. 6 followed by curettage. Incision was closed with vicryl no.1 and hemostasis achieved. B/L tubal ligation was done by modified Pomeroy's method. Patient stood the procedure well. Dressing done on D3 and stitch removal done on D8.

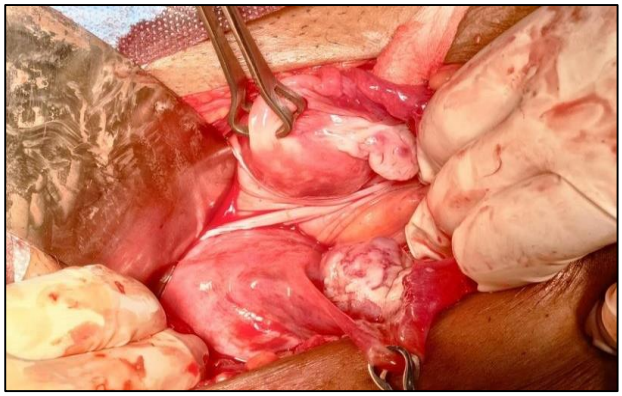

Figure 1: Two uterus with right and left ovary.

DISCUSSION

A didelphys uterus is a rare mullerian duct anomaly. Incidence is 0.5-5%. Most of the data on clinical significance and outcome of this uterine anomaly are based on small retrospective observational or case studies. Most women with didelphysuterus are asymptomatic but may present with dyspareunia or dysmenorrhea's fertility of women with didelphys uterus is less than women with normal uterus but better than women with other mullerian anomaly.

Didelphys uterus always does not seem to cause pregnancy complications as inour case report, the patient had three successful term deliveries with undiagnosed didelphys uterus.

Abdullah and Aliya described a primigravida with 12 weeks pregnancy where a pelvic USG showed empty uterus and adnexal mass which was misdiagnosed as ectopic pregnancy. Intraoperatively she was diagnosed to have a didelphys uterussame as in our case report.

MRI is gold standard for diagnosis of didelphys uterus. 3D/4D USG provide similarimages to those obtained by MRI. If only the uterine cavity is to be studied, HSG and hysteroscopy are essential, but if we want to see the shape of uterine fundus,laproscopy or laprotomy are essential.[3,5]

Termination of pregnancy with uterine anomalies is quite challenging. Medicalmethods and suction and evacuation are the methods of termination.

Mifepristone and misoprostol have been effective combination in medical termination of pregnancy, although other agents like methotrexate are also used.[1]

Patients with uterine and cervical anomalies who undergo surgical termination ofpregnancy are at increased risk of uterine perforation and adhesion formation.

They are also more likely to be subjected to repeat surgical attempts of termination and associated risk of GA.[2]

In such case surgical termination should preferably be done USG guided which was not available in our case. Detection of uterine anomaly by 2D USG is operator dependent which challenges the imaging skill of sonologist.

Medical termination of pregnancy is preferred choice in mullerian duct anomaly, but in our case laprotomy was done as USG diagnosed it as ectopic pregnancy.[4]

CONCLUSION

Some mullerian anomalies are easily diagnosed, but others have unusual presentation that make diagnosis and therapy difficult. A good knowledge of basic embryology is important for understanding the pathogenesis and clinical features of anomalies. Imaging plays important role in diagnosis of uterine anomalies.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. EL-Rafey, Rajasekar DR, Abdullah M, Calder I, Tempton A, Induction of abortion with mifepristone and oral/ vaginal misoprostol. N Engl J Med. 1995;332(15);983-7.
2. Jeremy K, Oyelese O, Bourne T, Uterine anomalies and failed surgical termination of pregnancy. The role of routine sonography USG Obstet Gynecol. 1999;14(6):431-3.
3. Jurkovic D, Gruboeck K, Ultrasound screening for congenital uterine anomalies. An Int J Obstet Gynaecol. 1997;104(11):1320-1.
4. Lazenby GB, Huang C, Rahall AM, Fogelson IS, Pregnancy termination via laprotomy in a woman with bicornuate uterus, Contraception. 2007;75:241-3.
5. Pellertio JS, McCarthy SMDM. Diagnosis of uterine anomalies: relative accuracy of MR imaging endovaginal sonography and hysterosalpingography Radiology. 1992;183(3):795-800.

Cite this article as: Sagar A, Sagar N, Dogra K. Dilemma in diagnosis of pregnancy in didelphys uterus: a original case report. Int J Reprod Contracept Obstet Gynecol 2024;13:444-5.