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Case Report

A case of rudimentory horn ectopic pregnancy

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ABSTRACT

Ectopic pregnancy is emergency in obstetrics. Sometimes difficult to diagnose make it difficult to manage. There are various types of ectopic pregnancy and each possible a variety of challenges. This is a case of a 20-year-old who presented to R. L. Jalappa hospital, Kolar with history of 3 months of amenorrhea and complaints of pain abdomen. She was in state of shock and after evaluation taken up for emergency exploratory laparotomy where the diagnosis of ruptured horn ectopic of a uni-cornuate uterus was made and treated accordingly.

Keywords: Ectopic, Rudimentary horn, Shock, Ruptured ectopic

INTRODUCTION

Unicornuate uterus is seen in with a prevalence of 0.1%. Unicornuate uterus occur due to incomplete development of one mullerian duct.[1] A unicornuate uterus can be with or without rudimentary horn which can either be communicating (when the horn fuse with the uterus) or non-communicating (when the horn is separate). Incomplete development of one mullerian duct gives rise to an apparent unicornuate malformation which has a fallopian tube and round ligament though rudimentary on the affected side.[2] Pregnancy occurring in the rudimentary horn is very rare and is usually difficult to diagnose as may present with rupture and hemoperitoneum. Most rudimentary horn pregnancies when undetected present with uterine rupture at 10-15 weeks gestation.

CASE REPORT

A 20-year-old gravida 3, para 2, live 2 referred from a peripheral PHC with suspected ruptured ectopic pregnancy. She gave a history of 3 months of amenorrhea with complaints of pain abdomen since one day, generalized in nature. She had two episodes of vomiting on arrival. She had no personal or family history of hypertension or diabetes or any ectopic pregnancies. She did not give any history of chronic pelvic pain. She had two uneventful pregnancies with live children delivered vaginally.

On examination her vitals were, PR-122 bpm, SBP-60 mmHg, RR-24 cpm, SpO_2-98% RA. She was conscious and oriented to surroundings. Her conjunctiva was paper white with cold extremities and dry tongue and mucosa. Chest was clear and two heart sounds heard. On abdominal examination there was diffuse tenderness noted. On per vaginal examination cervical OS was closed with fullness in the left fornix and cervical motion tenderness. On ultrasonography, findings suggestive of left side tubal ruptured ectopic with gross free fluid in abdomen.

She is resuscitated with crystalloids and investigated for blood group (B positive) and complete blood count. Hemoglobin reported to be 8 g/dl; WBC-25 Th/mm^3; platelets-345 Th/mm^3. 3 units of cross matched PRBC was arranged and she was prepped for laparotomy.

Intraoperatively hemoperitoneum of 1000 ml noted with left ruptured rudimentary horn ectopic. Abortus with placenta found floating in the peritoneal cavity with attachment to the cavity of the rudimentary horn. There was a cavity for the rudimentary horn which was attached

to the unicornuate uterus with a fibrous band. The left sided ovary and fallopian tube were directly attached to the rudimentary horn rather than the unicornuate uterus.

Figure 1: Intraoperative picture of hemoperitoneum and fetus.

Figure 2: Ruptured rudimentary horn.

Figure 3: Excised horn and fetus.

Hemoperitoneum suctioned and products of conception removed out. The round ligament of the horn was clamped, cut and ligated. The ruptured horn was clamped at base and resected. Left salpingectomy done. Base was ligated and hemostasis achieved. Hemostasis was ensured and abdomen closed in layers.

After transfusing 3 units of cross matched blood the post operative hemoglobin improved to 8.7 g/dl. she was advised for oral and parenteral iron supplementation. Advised for early ultrasound examination in case of a positive UPT to avoid delayed detection of ectopic pregnancy.

DISCUSSION

The mechanism of the occurrence of pregnancy in rudimentary horn is largely unknown. There will be high chances of rupture of the horn around 10-15 weeks.[1] Thus, posing serious problem to maternal health. Creating awareness regarding ectopic pregnancy and early ultrasonography for early diagnosis and management is very important. This would have been helpful in our case, as the patient presented in shock due to ruptured rudimentary horn with anemia due to acute blood loss.

The natural fate of rudimentary horn ectopic is rupture due to underdevelopment, variable thickness and poor distensibility of the myometrium. Only few cases of rudimentary horn ectopic were diagnosed early due to rupture. Placement of Foley catheter in intrauterine cavity and performing a trans abdominal ultrasound scan can exclude an intrauterine pregnancy.[2] It is also used to detect whether the horn is communicating with uterine cavity or not.

The mainstay management is resection of the rudimentary horn with ipsilateral fallopian tube and ovary either by laparotomy or laparoscopy.[3] There should not be delay in surgery once rudimentary horn pregnancy is diagnosed either in unruptured state as the timing of rupture depends on thickness of horn musculature and once it ruptures the effects will be catastrophic. Patient should also be evaluated for urinary anomalies, as some cases revealed absent kidney on ipsilateral side.

CONCLUSION

There is a great need for awareness regarding ectopic pregnancy and early ultrasound for diagnosis and management. The mainstay management is always a laparotomy. In this case immediate laparotomy helped in treating the cause of acute blood loss and then correcting anemia was easier in treatment.

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