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Viable pregnancy in a horn of a bicornuate uterus mimicking abruptio placenta: a case report

Ezem BU, Okeodo C

St Elizabeth Specialist Hospital and ART Centre, Owerri. Email: firstezem@yahoo.com

Abstract

Congenital abnormalities of the uterus have a prevalence of 1-10% in the general population. This case report is of a bicornuate uterus mimicking abruptio in pregnancy. A caesarean section was done and a live female baby was delivered. The case highlights the importance of a careful first trimester ultrasound for early detection of such cases.

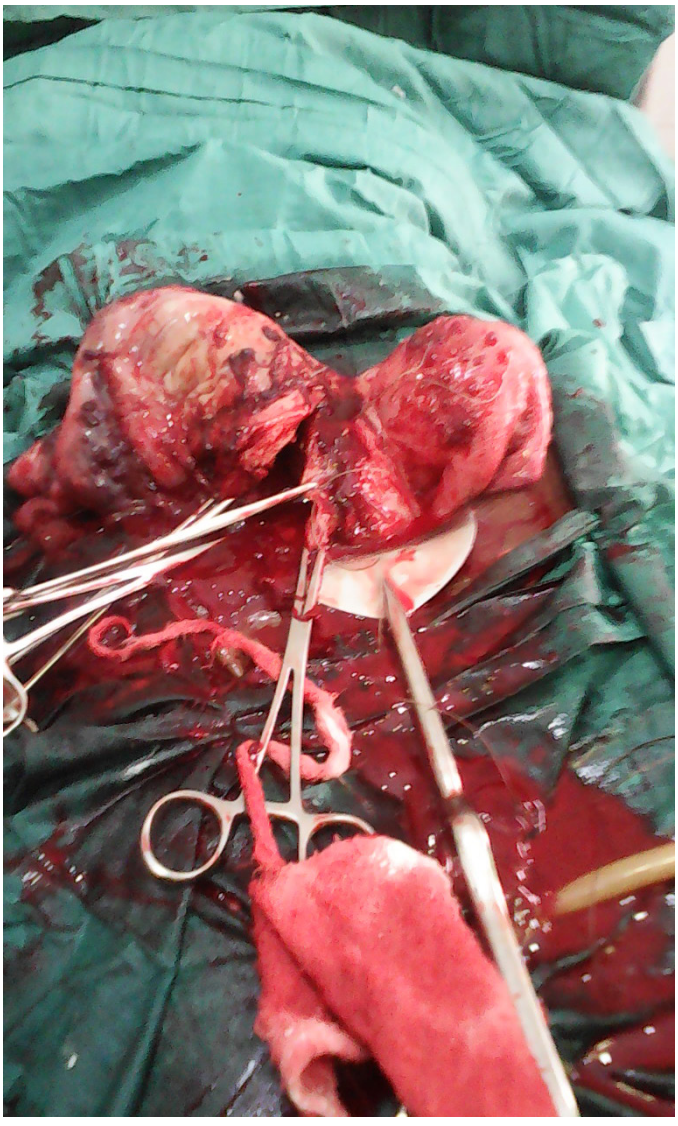
Key words: Bicornuate uterus, Live baby, Abruptio

Introduction

The development of the uterus results from confluence of paramesonephric ducts between week 7 and 10 of gestation. This process, known as, Mullerian organogenesis also represents the development of the upper two-thirds of the vagina, the cervix, and both fallopian tubes. The intervening mesoderm degenerates and a uterus with a single cavity is formed. Various degrees of disruption of this process lead to abnormalities which range from subseptate uterus to uterus didelphys. In the latter no fusion at all occurs leading to the duplication of the vagina, cervix and uterus. These abnormalities are generally rare and have a prevalence rate of 1-10%. Associated congenital anomalies include those of the urogenital system, gastrointestinal tract, cardiovascular and other Mullerian duct anomalies. They have been known to present with dysmenorrhoea, early pregnancy loss malpresentations and obstructed labour. The case below is presented because of its rarity and its mode of presentation.

Case Report

Mrs C.I who was Para 2+0 was twelve weeks pregnant when she registered for antenatal care. Her LMP was on 4th April 2016. She had two previous vaginal deliveries at term. Her booking parameters were height 1.72meters, weight 61 kg, blood pressure 110/70 mm of Hg. All her routine antenatal tests were normal. She attended for antenatal care regularly but at a gestation of 34wks+4days she presented with sudden onset of severe generalized abdominal pain. On examination she was afebrile, not pale, not dehydrated, and had no pedal oedema. Her chest was clear and blood pressure and pulse were normal. In the abdomen the symphysio- fundal height was 34cm and there was severe tenderness all over the fundus. Findings from systemic examination were essentially normal. Vaginal examination showed a closed cervix and no vaginal bleeding. Ultrasound showed a live foetus (FH 144 bpm) in longitudinal lie but breech presentation, the placenta was fundal and anterior. A preliminary diagnosis of concealed abruption placenta was made. No congenital abnormalities were detected at this point. Packed cell volume was 36% and urinalysis was normal. She was managed conservatively with analgesics, haematinics and dexamethasone in anticipation of a preterm delivery. She improved considerably and was discharged after three days. At 36wks +1 day weeks gestation she presented again with more severe generalised abdominal pain. The foetus was in longitudinal lie with a breech presentation and foetal heart was present. A diagnosis of concealed abruption placenta was made. At emergency lower segment caesarean section a bicornuate uterus was seen (Figure 1) with the foetus in the right horn.



Large blood vessels were seen on the anterior wall of the uterus and about 100mls of blood presumably from the blood vessels referred to above was seen in the peritoneal cavity. A live female foetus, Apgar 8/10 weighing 2.3kg was delivered. The placenta separated easily and no retro placental clots were seen. Peritoneal toileting followed by layered closure was done. The patient had primary postpartum haemorrhage which was successfully treated with blood transfusion and utero tonic agents.

Discussion

Bicornuate uterus may be asymptomatic or be associated with adverse reproductive outcomes like dyspareunia, dysmenorrhoea, and infertility. In the first trimester of pregnancy it may present as threatened abortion, spontaneous or recurrent miscarriages (2). In the second and third trimester's preterm labour, intrauterine growth restriction malpresentations may occur. Increased caesarean section rate and ruptured uterus have also been described (2). Some of these were present in this case. Diagnosis in pregnancy is often by chance when complications occur although it is possible to diagnose it during a first trimester ultrasound scan (3). Given the fact that most of the patients seen in our facilities, are first seen in the second trimester, diagnosis in the first trimester rarely occurs. It is important to note that previous normal vaginal delivery does not necessarily eliminate the possibility of the uterine abnormality as was demonstrated in this case and other cases where deliveries predating the index pregnancy were uneventful (4). Severe abdominal pain in pregnancy has been observed in some studies but no explanations were proffered (2). In this patient the severe abdominal pain was due to peritoneal irritation. This is to our knowledge the first report of this form of presentation. When severe abdominal pain of unknown aetiology occurs in pregnancy a uterine malformation should be considered as a possible diagnosis. There is no need to remove the other horn at caesarean section except it can be done with minimal complications since pregnancies have been known to occur in them subsequently (5, 6). Permission to publish this report was obtained from the patient.

Conclusion

This rare condition has been presented to alert obstetricians to the possibility that bicornuate uterus may present with severe generalised abdominal pain in the third trimester thus mimicking abruptio placenta. The case demonstrates the importance of a carefully performed first trimester ultrasound in pregnancy to allow for timely diagnosis and management.

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