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VARIATIONS IN CLINICAL PRESENTATION OF UNICORNUATE UTERUS WITH RUDIMENTARY HORN-DIAGNOSTIC ENIGMA

Gynecology

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ABSTRACT

Aim: To review the presentation,diagnosis management and outcome of unicornuate uterus with non communicating rudimentary horn.

Introduction: The unicornuate uterus is a rare uterine mal-formation with prevalence of 2.4-13.7% of all uterine malformations (1)which usually features a rudimentary horn in more than 75% of the cases. Pregnancy in the rudimentary horn is rare,but the complications with such pregnancies could be presented as the first clinical manifestation of rudimentary horn.

Case reports: We hereby describe three cases of unicornuate uterus with rudimentary horn,each one with different clinical presentation and without any correct pre-operative diagnosis and hence-forth reflect on the practical aspects learnt about the diagnosis and management of this rare malformation.

Conclusion: Our experience with unicornuate uterus with rudimentary horn in parous women who are asymptomatic and un-aware of this rare malformation are reported in medical literature. we highlight the need for the greater awareness regarding this genital malformation for differential diagnosis and accurate treatment in emergency situations.

KEYWORDS

Unicornuate Uterus, Rudimentary Horn, Pregnancy

AIM: The aim of this study is to review the presentation, diagnosis, investigations, management and outcome in women with unicornuate uterus with non communicating rudimentary horn.

INTRODUCTION:

This retrospective study consisted of three women diagnosed as having unicornuate uterus with rudimentary horn with varying presentation.

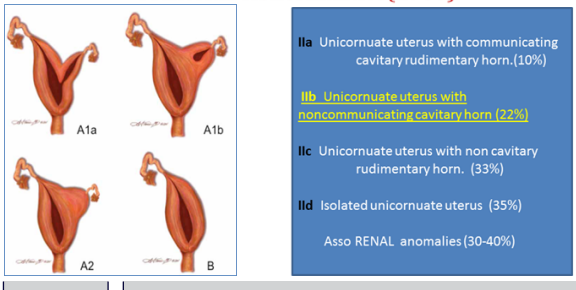
The incidence of mullerian duct anomalies varies in general population it is 3.2%. (2) Unicornuate uterus constitutes approximately 20% of all mmullerian duct anomalies and most of the women were asymptomatic until menarche or if andwhen they become pregnant.

TABLE 1:

American society of reproductive medicine classification of mullerian anomalies 1988 most popular than EESHRE-ESGE.

CLASS	ANOMALY
1	Utero vaginal hypoplasic/agenesis
2	Unicornuate uterus (with or without rudimatory horn, banana shaped) a)communicating b)non communicating c)no cavity d)no horn
3	Uterus didelply
4	Bicornuate uterus a)complete bicornis / bicollis b)Partial- bicornis uricollis
	Septate uterus
5	Arcuate uterus
	Uterine anomalies related to DES exposure

AFS/ ASRM Classification of Mullerian Abnormalities(1988)



Unicornuate uterus is a result of abnormal or failed development of one of the paired mullerian ducts.This group of anomalies are further subdivided into 4 variants according to American fertility society. (3) The isolated unicornuate uterus is the most common with a reported frequency of 35%. When a rudimentary horn is present, it is non-cavity in 33% of cases,cavity non-community in 22% and cavity communicating in 10%, usually associated with renal anomalies (ipsilateral).(4) The prevalence of unicornuate uterus with rudimentary horn(UUWRH) in fertile women is approximately 1 in 100,000.

(5, 6) The pregnancy incidence in a non-community horn is 1 in 76,000 to 1,50,000. Pregnancies and only 14% of the cases are correctly diagnoses before clinical manifestations make themselves apparent.

(7)Gestation in rudimentary horn occurs by transperitional migration of sperm/egg during impregnation period.

Clinical implications:

Women with unicornuate uterus with rudimentary horn(UUWRH)will have an increased incidence of gynaecological problems commencing from menanche to later part of reproductive life.Depending on the class of unicornuate uterus,these symptoms will range from dysmenorrhoea, chronic pelvic pain, hematometra,hematosalpinx and varying degrees of endometriosis and adenomyosis.

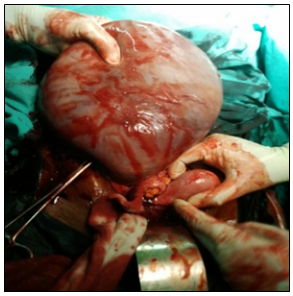
Here we describe three clinical cases with final diagnosis of UUWRH with different clinical presentations in each case and analyse the problem in thediagnosis and how they need to be handled.written consent was obtained from all the women and ethical committee permission was taken.

Case reports:

Case 1 –

A 28 year G4P3L3 with7MA, unbooked case presented to labour room with pain abdomen of one day duration with normal vitals. Previous deliveries were normal vaginal deliveries. USG showed single fetus of 26 wk.Gestation with fetal brady-cardia,provisionally diagnosed as preterm labour (with patulous cervix) patient was complaining of increased intensity of pain.Case was reassessed after 4 hrs due to increasing uterine contractions with no servical changes and meternal tachycardia associated with tense, tender uterus. Emergency laparotomy was planed thinking the possibility of cervical dystosia with abruption. Adequate conpativiu blood was arranged. Laparotomy showed the pregnant rudimentary horn with torsion of 120 degrees towards right side. With singns of isshemia (bluish discolormtation noted) excision of the rudimentary horn was done along with tubectomy. Patient had smooth recovery.

Intraoperative findings



-Pregnancy in rudimentary horn (right side)with torsion of 120 ° towards right side with signs of ischemia (bluish discoloration of horn) present.
-Excision of Rudimentary horn after removing dead foetus with placenta(no retroplacental clots)
-B/l tubectomy performed
-Recovery smooth and discharged.

CASE 2-

A28 yrs G3 P2 L2 with 4MA presented to labour with pain abdomen and shock Trans abdominal ultrasound brought to light in extra-uterine dead fetus of 16 week with hemoperitoneum,initial tentative diagnosis was ruptuned ectopic pregnancy / abdominal pregnancy.An emergency laparotomy was planned with compatible blood laparotomy revealed hemoperitoneum with a dead fetus of 16 week with placenta lying in the peritoneal cavity,with ruptune of rudimentary horn on right side of unicornuate uterus.The rent in the ruptured horn was sutured with 1/0 vicryl,hemostasis secured along with tubectory on both sides.Resection of NCRH (non-communicating-rudimentary horn) was not done as the patient was hemodynamically unstable.Post of period was unrema rkable.

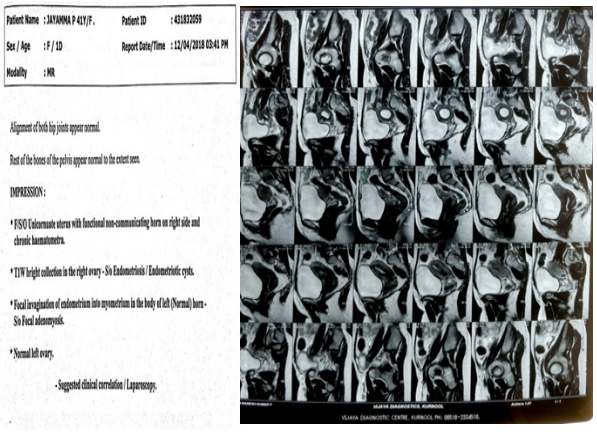
Unicornuate uterus with repaired ruptured Left horn



CASE 3-

A 40 yrs P3 L3 presented to OPD with chronic pain abdomen of 2 yrs duration,having(congestive) dysmenorrhoea. All are normal vaginal deliveries conducted by TBA.USG revealed a subserous fibroid on right side,with cystic degeneration.MRI pelvis was performed to get better information,MRI result came as unicornuate uterus with ademomyosis and hemato-metra of rudimentary horn. Normally women with NCRH will present with hemoto metra in early part of they reproductive life contrary to this our patient presented after having completed her family.

Latarotomy was done which showed hematosaltinx with hematometra on right side hysterectomy was planed as there was coexisting adenomyosis along with hematometra of NCRH.Patient had good post of recovery.



Patient Name : JAYAMMA P 41Y/F. Patient ID : 431832059
Sex / Age : F / 1D Report Date/Time : 12/04/2018 02:41 PM
Modality : MR

Alignment of both hip joints appear normal.

Rest of the bones of the pelvis appear normal to the extent seen.

IMPRESSION :

* HSO Unicornuate uterus with functional non-communicating horn on right side and chronic haematometra.

* T1W bright collection in the right ovary - S/o Endometrioids / Endometriotic cysts.

* Focal invagination of endometrium into myometrium in the body of left (Normal) horn - S/o Focal adenomyosis.

* Normal left ovary.

- Suggested clinical correlation / Laparoscopy.

Table 2 – summary , signs , diagnosis, and management of the 3 cases in the text .

Symptoms	Inv	Diagnosis	Management
Case 1) parous women with pain in Late second - trimester of pregnancy	USG single intra uterine fetus	Laparotoy Torsion of rudimentary Horn With Pregnancy.	Excision Of rudimentary Horn
Case 2) Acute Abdomen in 2nd Trimester with Shock	USG Hemo-paritonem And extra uterine dead fetus.	Ectopic pregnancy with ruphune	Laparotomy with repair of rent in NCRH
Case 3) ch. Pain abdomen in parous women	s/o subserious fibroad with degeneration MRI- hematometra with unicornuate uterus	Unicornuate uterus with hematometra and ademomyosis	Total abdominal hysterectary

DISCUSSION:

Diagnosis of asymptomatic UUWRH a challenge due to low prevalence and a lack of awareness and suspician among clinicians.Often the patients medical history completely normal and symptoms depend on the type of anomaly.Cases of non-communicated and cavitated unicornuate uterus but may present a differential diagnosis with the didelphys uterus.Utarosacrals would be inserted in to the principal horn,where as in didelphys uterus each utrosecral ligament would be inserted in to each uterus.ML sanchez ferrer presented in their study a series of 5 cases of UUWRH with ectopic pregnancy with rupture of rudimentory horn is the commonest presentation,torsion of rudinatory horn with pregnancy is rarely seen uterine torsion is defined as a rotation of the uterus more than 45 degrees on its long axis it is an unusual complication of pregnancy and for most obstetricians it probably presents once a life time diagnosis (8)With clinical suspicion and use of MRI we can diagnose this a normally at an early time with appropriate management.

CONCLUSION :

We here in describe a series of cases related to UUWRH by explaining its differencial diagnosis based on embryo-logical origin and a discussion on its optimal management.Every effort should be made to diagnose this condition and rudimentary horn should be excised when ever diagnosed to decrease the serious complications in future Conflict of interest – Nil

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