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A Case of Uterus Didelphys With Prolapse

KEYWORDS: Uterus Didelphys, Mullerian Anomalies, Prolapse

Dr Padmalata
Professor, Department of Obstetrics & Gynaecology, SVS Medical College Hospital, Mahabubnagar, Telangana, India.

Dr Naima Fathima
Associate Professor, Department of Obstetrics &Gynaecology, SVS Medical College Hospital, Mahabubnagar, Telangana, India.

ABSTRACT *Mullerian anomalies are a result of defective development and can cause various problems. Most of the anomalies are detected during reproductive years during investigations for infertility, recurrent miscarriages or other pregnancy complications. Uterus didelphys is known to be associated with good pregnancy outcome. We present a case of Uterus Didelphys in a woman who had three full term uneventful pregnancies and presented to us with third degree prolapse after menopause. It is not a common finding now a days.*

Mrs V, 60 years old, house wife by occupation, from a village presented with mass per vagina since 2 years. The mass was gradually increasing in nature. Initially it was reducible by lying down and manually. Presently it is reduced only manually. She complained of difficulty in urination and defaecation which she is able to do only after reducing the mass manually. There is no history of cough of long standing duration, constipation or lifting heavy objects. She had been post menopausal since 10years. No history of postmenopausal bleeding. She is Para3. She had a full term normal vaginal delivery at home which was conducted by an untrained dai. No history of prolonged labour or big baby. Male baby died after 4months of birth due to some illness. During her second pregnancy she again had a full term vaginal delivery conducted by a local dai and delivered an average sized female baby. The baby died after 8 years due to accidental fall in a well. Third pregnancy she delivered at home after full term a female baby, who is 28 years now. There is no history of abortions. No significant past and family history. General examination showed her to be pale, average built, normal gait. Local examination external genitalia to be atrophic, with sparse pubic hair. Two cervices and two external os were seen outside the introitus. There was moderate cystocele and rectocele. There was no evidence of any vaginal septum. On bimanual examination uterus was found to be small in size and retroverted and both the fornices were free. Routine blood tests were normal. USG revealed two uteruses and two cervices which are displaced quite low with endometrial thickness of 3mm. No associated urinary tract anomalies were noted. After preoperative preparation she underwent vaginal Hysterectomy with Cystocele and Rectocele repair. She was discharged after 7 days of uneventful postoperative period. Histopathology of the specimen confirmed two separate endometrial cavities and two separates fundi.

Discussion: Uterus Didelphys is a Class III Mullerian Anomaly which is due to failure of fusion of two Mullerian ducts. This results in duplication of uterine horns, duplication of cervix without any communication between them. Sometimes there may be a septum in the vagina which may be complete or incomplete. Females are usually asymptomatic and can present at a young age with haematometrocolpos, haematosalpinx if there is obstruction in the vagina due to septum. In a case series of 26 females with uterus Didelphys symptoms of dysmenorrhoea, dyspareunia and leucorrhoea were noted. Uterus Didelphys is known to be associated with pregnancy complications such as spontaneous abortion, preterm labour, cervical incompetence and malpresentations. It may be an incidental finding during a caesarean section done for other indications. Pregnancy outcomes are relatively good compared with other uterine anomalies. In one case series pregnancy in the right horn was commoner than left horn. If one horn accommodates pregnancies, there may be slight disparity between the size of two horns. If Uterine Didelphys is present it is necessary to insert 2 IUCDs for contraception. In a postmenopausal woman there is a possibility of endometrial carcinoma developing in one horn. Our patient had three full term deliveries and was asymptomatic and if not for development of prolapse, it would have gone unnoticed.

Fig 1. Two cervices with uterine sound in each one of them.

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Fig2. Two uterine horns seen

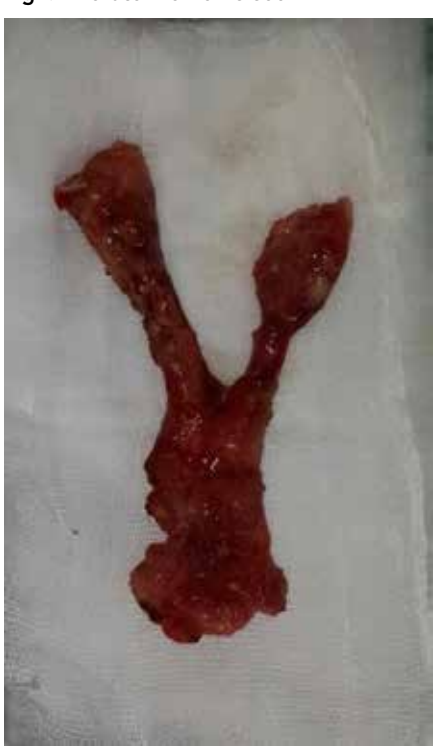

Fig3.right horn bigger than left horn.

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