



A CASE SERIES OF VARIOUS PARAMETERS ASSOCIATED WITH MULLERIAN ANOMOLIES IN PREGNANCY.

Dr Bhavna Trivedi	SMC, Department of OBGY, HBTMC and Cooper Hospital, Mumbai, Maharashtra, India.
Dr Shraddha Mevada*	Assistant Professor ,Department of OBGY, HBTMC and Cooper Hospital, Mumbai, Maharashtra, India. *Corresponding Author
Dr Sneha D Shirodkar	Head of Department ,Department of OBGY, HBTMC and Cooper Hospital, Mumbai, Maharashtra, India.

ABSTRACT Congenital Mullerian anomalies are known to have higher incidence of infertility, intrauterine growth restriction, foetal malposition, preterm labour, preterm premature rupture of membrane and increased cesarean section rate. We studied a series of 7 patients in our tertiary care institute who had Mullerian anomalies and various parameters associated with the same. Our series reported that 85.72% patients had LSCS as maternal outcome and 14.28% had vaginal mode of delivery .It was noted that Bicornuate uterus as the most common anomaly as compared others uterine malformations. We recommend early 1st trimester ultrasound scans should be routinely done as part of our clinical work which will help in diagnosis of such high risk uterine anomalies and thus avoiding untoward maternal and neonatal complications.

KEYWORDS : Congenital uterine anomalies, Pregnancy outcomes, Preterm birth.

INTRODUCTION:

Congenital Mullerian uterine anomalies and malformations result from an abnormal formation, fusion or reabsorption of Mullerian ducts during fetal life. According to statistics, these anomalies are present in 1 to 10% of the unselected population, 2 to 8% of infertile women and 5 to 30% of women with a history of miscarriages¹. It has also been found that the presence of a maternal uterine anomaly is usually associated with an increased risk of preterm birth rate, preterm premature rupture of membranes, breech malpresentation, Lower Segment Cesarean Section, placenta previa, Abruptio placenta and intrauterine growth retardation (IUGR).²

METHODS:

The series of 7 patients were studied in a tertiary care institute during a period of 1 year. Various parameters like incidental or antenatal diagnosis of Mullerian anomalies, presenting complaints, gestational age, maternal and neonatal outcomes were studied.

Case 1:

35year old P5L2NND3 with preterm 33.5 weeks b/s vaginal delivery at peripheral hospital with placenta insitu was seen in Emergency suite. Patient was vitally stable. Examination findings revealed placental tissue adherent to fundal and posterior wall with cord in insitu. No active bleeding was seen. Attempt of Manual Removal of Placenta was done, but unfortunately the procedure was abandoned due to adherence. MRI was done which was suggestive of retained placenta in Postpartum involuted bicornuate unicollis uterus with features of placenta increta. Medical management with methotrexate was done and serial monitoring of Bhcg levels on OPD basis which was in decreasing levels. However, patient complained of spotting per vagina on every follow up visit and on repeated ultrasonography findings there was no significant reduction of size in placental tissue. Hence, decision of abdominal hysterectomy was taken. Patient recovered well and was discharged on postoperative day 5.

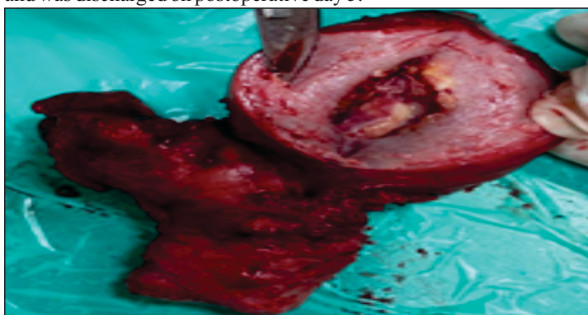


Figure1: Cut Section Of Hysterectomised Bicornuate Unicollis Uterus With Retained Placental Tissue.

Case 2:

Primigravidae with 35 weeks 5 days of gestation was attended in labour suite with Preterm premature rupture of membrane; Induction of labour was done. Emergency LSCS was done in view of failure of induction. Incidental intraoperative findings of Bicornuate uterus with pregnancy in right horn and noncommunicating accessory left horn. Male baby of 2045 grams was delivered with cephalic presentation.

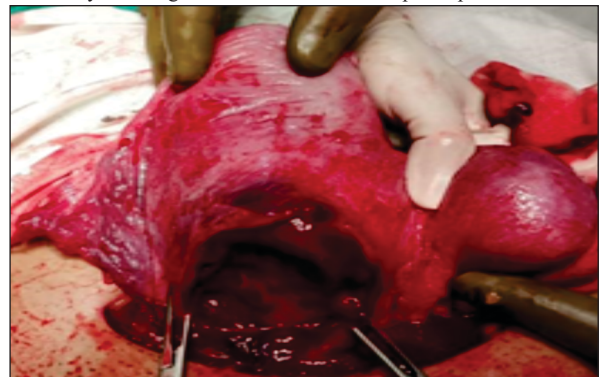


Figure 2: Bicornuate Uterus With Pregnancy In Right Horn And Accessory Left Horn

Case 3:

Elective LSCS was done for a G3P2L2 with previous 2 LSCS at 38 weeks 3 days of gestation with antenatal diagnosis of Uterine didelphys. Female baby of 3506 gram was delivered uneventfully with cephalic presentation.



Figure 3: Uterine Didelphys With Pregnancy In Left Horn

Case4:

G3P2L2 with previous normal delivery followed by LSCS with 38 weeks of gestation was taken up for Elective LSCS in view of Previous LSCS not willing for trial of labour. Intraoperatively incidental finding of Arcuate uterus was noted. Surgery was uneventful with the delivery of healthy male child of 3456 grams.

Case5:

G2A1 with infertility conception was Elective taken up for LSCS, which was antenatal diagnosed with Septate uterus, healthy female child of 2456 grams was delivered.

Case6:

Primigravidae with antenatal diagnosis of bicornuate uterus with twin gestation, with each gestation in each horn was electively taken up for LSCS at 37 weeks 5 days of gestation. Healthy male child of 2455 grams with cephalic presentation in right horn and healthy female child with 2140 grams with breech presentation was delivered.

Case 7:

G2A1 with antenatal diagnosis of bicornuate uterus with longitudinal vaginal septum was electively taken for LSCS at 37 weeks 3 days; healthy male child with cephalic presentation was delivered.

DISCUSSION AND CONCLUSIONS:

In our series we found that, 4 patients had Bicornuate uterus as anomaly (57.14%), 1 case of uterine didelphys (14.28%), 1 case of Arcuate uterus (14.28%) and 1 case of Septate uterus (14.28%). We found Bicornuate uterus as the most common anomaly as compared to other uterine malformations (58%). Our findings were similar to study done by R Ngarathnamma et al.³ Out of 4 patients of bicornuate uterus, 2 had preterm delivery and 2 had full term delivery. Only 2 babies required NICU admissions. Vertex was the most common presentation in our series (85.72%), only 1 patient had breech as presentation (14.28%). It was similar to study conducted by Neha et al, in which they found vertex as presenting part (53.3%).⁴

Maternal outcome showed 1 vaginal delivery, 1 Emergency LSCS, and rest all patients had Elective LSCS. Thus we found that 6 patients (85.72%) had LSCS as maternal outcome, only 1 patient (14.28%) had vaginal mode of delivery. Our study had finding consistent with a similar study where 80% had LSCS rate.

We found that 4 cases were antenatal diagnosed (57.14%) and remaining 3 had incidental findings (43%) of uterine anomalies.

We should make sure that early 1st trimester ultrasound scans are routinely done as part of our clinical work which will help in diagnosis of uterine anomalies. Such high risk patients require more follow-ups; senior obstetrician, deliveries at higher centres to prevent untoward maternal and fetal complications.

Consent:

Written informed consent was obtained from all the patients for publication of these case series and any accompanying images.

Conflict Of Interest: None**Acknowledgement:** None**REFERENCES:**

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