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Case Study

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A CASE REPORT OF PREGNANCY IN UNSUSPECTED MULLERIAN DUCT ANOMALY

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INTRODUCTION

Müllerian duct anomalies (MDAs) are a group of congenital anomalies of the female reproductive tract which occur due to abnormal embryological development of Mullerian ducts in utero. The didelphys uterus results from complete failure of the Mullerian ducts to fuse leading to formation of two separate uterine cavities and two cervices. It is one of the rare types and accounts for approximately 5% of all MDAs.[1,2] Despite its rarity, it is very crucial to detect these uterine anomalies as they are associated with adverse pregnancy outcomes.

CASE REPORT

A 25 year-old female presented with history of amenorrhea for past 3months. She has been married for 5 years and had medical history of infertility. Her previous workup for infertility was uneventful. Transabdominal ultrasound was attempted, but it was difficult to obtain images consistent with visualization of a definitive intrauterine pregnancy in a uterine anomaly. A transvaginal ultrasound scan revealed a uterine didelphys configuration with 2 cervix and 1 vagina with a well-formed single live intrauterine gestational sac showing fetal pole and yolk sac within in the right uterine cavity, CRL corresponding to 12week 4days.

Patient was referred to the Obstetric and Gynaecology Department and was counselled about the diagnosis and its favourable outcomes. On follow up, patient had spontaneous abortion after two weeks of presentation.

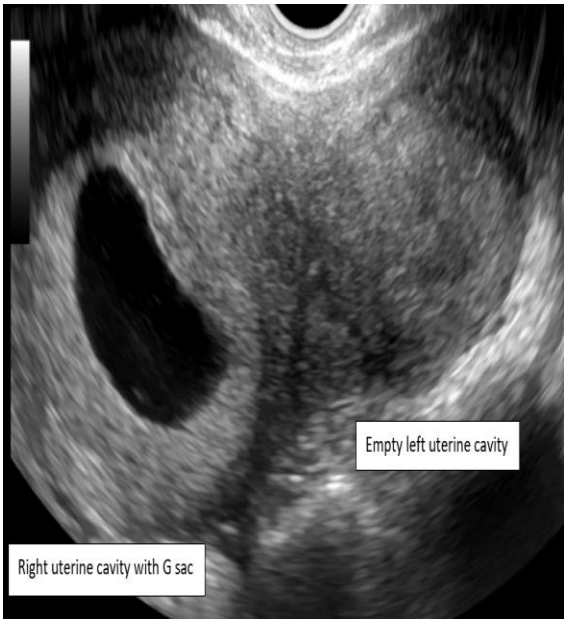

Figure 1(a)

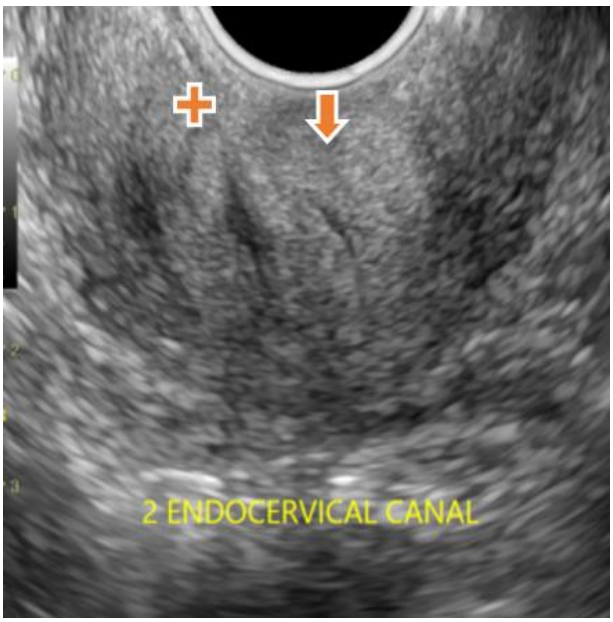

Figure 1(b)

Figure 1: Transvaginal ultrasound (Transverse views) of the uterus in Figure 1(a) demonstrate uterus didelphys with gestational sac in the right uterus and absence of gestation sac in left uterus. Figure 1(b) demonstrate two endocervical canals as marked with arrow and plus sign.

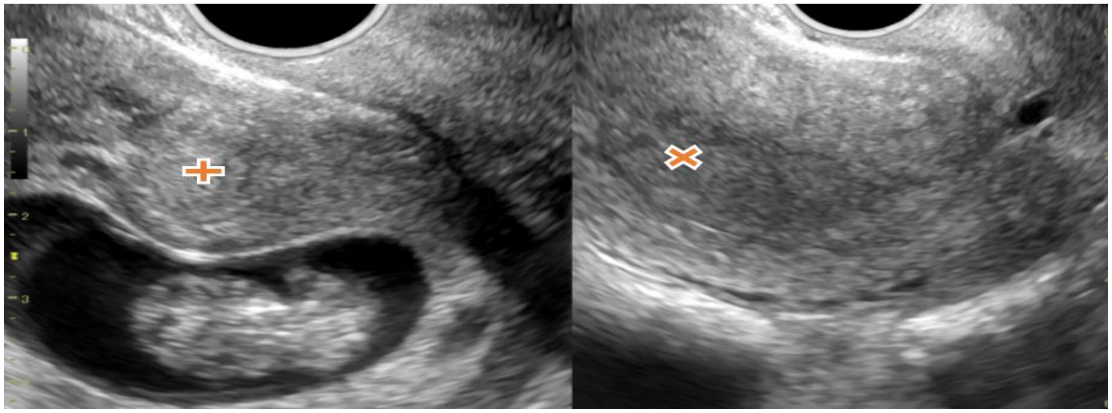

Figure 2: Transvaginal ultrasound (Saggital views) of the uterus demonstrate uterus didelphys configuration with gestational sac in the right uterus(marked with plus sign) and absence of gestation sac in left uterus(marked with cross sign).

DISCUSSION

Uterus didelphys is a rare anomaly and its rate of occurrence is found to be more frequent in female population with history of abortion and infertility and accounts for approx. 2.1%.[3] It is often asymptomatic and thereby has increased frequency of inaccurate assessment. It has varied gynaecological (pelvic discomfort, dysmenorrhea, dyspareunia, haematometra) and obstetric outcomes.[4] The ability to conceive is often a debatable issue, however pregnancy is often associated with reproductive failure.

It is often associated with vaginal septation (with estimation of approx. 70%) and exceedingly rare obstructed hemivagina and ipsilateral renal anomaly (OHVIRA), which is characterized by uterine didelphys, obstructing hemivagina, and ipsilateral renal agenesis.[5,6]

These cases remain undetected in majority of the patients, however imaging plays a crucial role in diagnosis of the anomaly. Ultrasound(Transvaginal) or hysterosalpingography are helpful in making initial diagnosis. MRI is the imaging modality of choice for accurate detection, which is essential to determine the most effective treatment during childbirth.[7] MRI is considered to be the best option because of its better anatomic assessment compared with other diagnostic modalities, thereby differentiates it better from other anomalies like bicornuate/septate uterus.

Surgical correction (metroplasty) is not usually indicated, however excision of the vaginal septum may be required if symptomatic. There is often no indication for primary caesarian section.[8]

CONCLUSION

Uterine anomalies, while rare, is a challenging scenario as majority cases remain unreported. However, early detection with imaging modalities especially in indeterminate cases, appropriate planning for delivery would allow to facilitate a safe outcome for both mother and neonate. The patient should always be informed of possible unfavorable pregnancy outcomes.

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