

# CASE REPORT

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## BICORNUATE UTERUS & PERINATAL OUTCOME

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**ABSTRACT: BACKGROUND:** To highlight the incidental finding of congenital anomaly of Uterus and its Perinatal outcome. The uterus and its appendages are a common site for congenital abnormalities although overall they are considered rare. One of the easily recognised and described mullerian duct anomalies is the bicornuate uterus, associated with infertility. It is associated with adverse obstetric outcome. We present a case of live term pregnancy in one horn of a bicornuate uterus with 3 years history of infertility. The antenatal period was uneventful. She delivered a live 2.8 kg. female baby after an emergency caesarean section. The post-partum period was uneventful and the patient was discharged home on the 8th post-operative day. **AIM:** We have decided to report this case because this case was managed successfully inspite of the uterine anomaly without putting circlage which by itself carries the risk of preterm labour, infection and anaesthetic complication.

**KEY WORDS:** Bicornuate uterus, infertility, circlage, perinatal outcome

**INTRODUCTION:** Female genital tract is formed from mullerian ducts and urogenital sinus. By 12<sup>th</sup> week of fetal life, uterus attains its normal, fused external uterine contour and triangular endometrial cavity. Ovaries are of different origin so mostly not involved in mullerian anomalies. Aetiology is unknown. 0.1% to 3% of woman and most studies report anomalies have problem with fertility and reproduction. Those anomalies are associated with miscarriage, premature labour, premature rupture of membrane and malpresentation.

**CASE REPORT:** A 23 year old lady gravida 2, abortion 1 with 9 months of amenorrhea, booked case(outside) came to hospital in labour. Her previous menstrual cycles were regular 3 - 4/28- 30 days and last menstrual period was 25.10.2012. First pregnancy ended with missed abortion, diagnosed by USG as bicornuate uterus (complete) with unicollis with missed abortion. D & E done. Patient was discharged. Following that hysterosalpingography was done later to confirm the finding. She presented to our hospital at 38 wks+4 days with c/o lower abdominal pain radiating to back and thighs without any eventful problem antenatally. On examination pulse 84/min, BP 132/84mm Hg, B/L vesicular breath sound no added sound, S<sub>1</sub> & S<sub>2</sub> were normal, no murmur. Per abdomen, uterus was 38wks size, contractions 0-1/15"-20"/10', relaxation good, fetal heart rate 140bpm. Per vaginal examination cervix-soft, 2cm dilatation, membranes intact, vertex presentation, station high up. Blood, urine and other parameters were within normal limits. Continuous fetal monitoring and induction with oxytocin started, labour did not progress well. She was shifted to operation theatre for emergency cesarean section. She delivered an alive female baby weighing 2.8 kgs. Post-operative period was uneventful. Sutures were removed on 8<sup>th</sup> postoperative day and patient was discharged.

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**Fig. 1: USG showing bicornuate uterus with fetus in utero in one horn**

**DISCUSSION:** A The uterus and its appendages are a common site for congenital abnormalities although overall they are considered rare. One of the easily recognised and described müllerian duct anomalies is the bicornuate uterus, associated with infertility. It is associated with adverse obstetric outcome<sup>1</sup>. According to Buttram and Gibbons (1979) classification based on the degree of failure of normal development and American Fertility Society- bicornuate uterus comes under class 4. Ultrasound scan remains the sole and reliable means of assessing the presence of these anomalies in pregnancy for safety reasons<sup>2</sup>. Three-dimensional sonography demonstrates all congenital uterine abnormalities with a sensitivity and specificity of 100%. It is less expensive and less invasive than hysterosalpingography for the assessment of uterine anatomy and diagnosis of müllerian duct abnormalities and enables the differentiation of septate from bicornuate uteri for preoperative surgical planning<sup>3</sup>.

Cerclages increased the live birth rate from 21 to 62%. These results confirm that patients with uterine malformations have higher rates of reproductive loss, pre-term delivery, breech presentation and complications that increase obstetric intervention and perinatal mortality<sup>4</sup>. Moreover in a study, pregnancy outcome was poorer in the bicornuate and arcuate uterus groups than in the septate group. Surgical intervention for müllerian anomalies is indicated in women with pelvic pain, endometriosis, obstructive anomalies, recurrent pregnancy loss, and preterm delivery. The reproductive potential of the bicornuate uterus showed a live birth rate of 62.5% and the septate uterus showed a live birth rate of 62%. In all these abnormalities, early miscarriages (25-38%) and preterm deliveries (25-47%) were quite common. The arcuate uterus presented a live birth rate of 82.7%<sup>5</sup>. But Müllerian anomalies, especially uterine anomalies, are associated with both normal and adverse reproductive outcomes, and management in infertile women remains controversial<sup>6</sup>.

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**Fig. 2 Intra-operative picture of bicornuate uterus**

**CONCLUSION:** Because the incidence of such pregnancies or fertility is low, it still remains an accidental finding, only during routine investigation or when recurrent pregnancy loss occurs. In our case, since there was no progress for spontaneous labour, vaginal deliveries increase the risk of dystocia and uterine rupture, cesarean section is a relative indication for a good perinatal outcome.

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