CASE REPORT

Pregnancy and Labour in a Case of Uterus Pseudodidelphys

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Abstract

Mullerian Duct abnormalities cause various congenital malformations in the female genital tract. These abnormalities have variable effects on pregnancy and its out come. Uterus didelphys and uterus pseudodidelphys are two extreme forms of these abnormalities which are rarely encountered in obstetrical practice. A young primigravida reported in labour and because of duplication of genital tract there was difficulty in the determination of stage of labour as well as diagnosis of labour. There was also problem associated with progress of labour and operative delivery. Same patient on a subsequent pregnancy reported with complications associated with presentation of foetus as well as preterm labour. This poses a diagnostic dialemma during labour. The insight into such an event can make us alert in diagnosis during such rare obstetrical encounters.

Key Words

Uterus Psedodidelphys, Mullerian Ducts, Rectovesical ligament, LSCS.

Introduction

If two mullerian ducts fail to fuse in the midline along whole of their lengths and keep on developing normally, they remain separate and a condition called uterus didelphys results. In uterus didelphys separate cervices are found at the apex of the vagina and there are two separate uterii above the cervices because there is no fusion between the two halves of the uterine body (1).

Uterus didelphys is distinguished from a condition known as bicornuate uterus by the presence of separate uterii and complete reduplication of cervices and two separate hemi uterine cavities (2).

In a series of 26 such cases, Heinonen reported overall successful pregnancies in 70% (3). In addition to 30% miscarriages there were preterm deliveries and foetal growth retardation in 10%. Forty three percent had breech presentation and LSCS rate was 82% (3).

Two separate uterine cavities are less likely to be associated with abnormal lies rather than the lesser degrees of fusion defects (4).

We are concerned with this condition as it affects the parturition as reported by Piquand (5) and Summarae (6).

Case Report

The present case was a primigravida, 24 years old reported to labour room with good uterine contractions. She did not have any antenatal record and no antenatal sonography was done as she came from a place where sonography facilities were not available.She was normotensive and had an average height and builtHer Hb was 9.0 grams, O+ve, blood group and had normal baseline investigations.

The doctor on duty reported that she was term, cephalic, and foetal heart was regular, Head was engaged and her

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cervix was 3/5th dilated.Although she was unable to asses the effacement and the adequacy of pelvis.About two hours later to her astonishment she found on pelvic examination that the os was closed and she did not feel the head. On a repeat examination it was found that she was 3/5th dilated. A small caput was formed and the cervix was loose and hanging. There was a visible septum in the midline. On examination of the septum, it was found that there was a separate vaginal opening and a separate cervix with a closed os. Patient was taken for L S C S for acute foetal distress diagnosed by persistent bradycardia and meconium stained amniotic fluid, with the diagnosis of mullerian fusion abnormality in mind.On L S C S a completely seprate 14-16 weeks sized non-gravid uterus was also seen with a clear cut vesico intestinal band between two separate uteri. The LSCS was without any intra operative complication and even the post operative period was normal.

Two years later the same patient reported with preterm labour with breech presentation and emergency LSCS was done with healthy outcome of mother and foetus.This time the vaginal septum was also excised under same sitting.

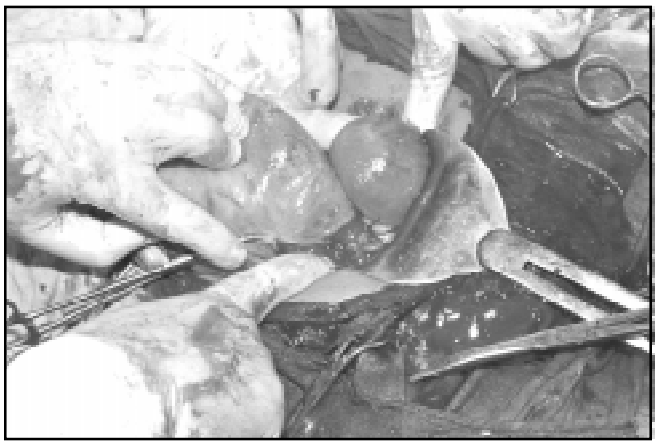

Fig. 1. Uterus Pseudodialphys with rectovesical septum during LSCS *RVS, A-Gravid uterus, B. Non-gravid enlarged uterus

Discussion

True uterus didelphys and pseudodidelphys are rarest of all duplications encountered and we find that the uterus, vagina, vulva are absolutely distinct on both sides. The bladder too may be duplicated and bowel lies between uterine bodies with a rectovesical ligament and the pelvis may be generally split. One of the most striking examples have been recorded by Gammel and Paterson (7).

Munrokerr have presented a theoretical and diagrammatic description of true uterus didelphys and uterus pseudodidelphys with a recto vesical ligament (8).

Generally vagina is double but in a number of cases vagina was single without any trace of septum. The septum is usually median and the two vaginal canal are equal in size. Not infrequently one canal is narrower than the other as usually only one of the two vagina are stretched during intercourse, Munrokerr has defined this condition as uterus pseudodidelphys as has been done by Piquand (5,8).

Conclusion

It is now covenient to draw the attetion of practising obstetricians towards a mistake frequently made during the routine examination in the course of labour i.e. to examine the wrong cervix for dilatation when ignorant about such abnormality.

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