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EC GYNAECOLOGY
Case Report

A Case of Ruptured Rudimentary Horn at 27 Weeks

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Abstract

Pregnancy in a non-communicating rudimentary horn in spite very difficult to diagnose before it ruptures, in this case it was suspiciously diagnosed at 7 weeks pregnancy. Unfortunately intervention occurred only after it ruptured. However Knowing the detailed history of this pt helped in saving her life and helped in the timely laparotomy.

Keywords: *Rudimentary Horn; 27 Weeks; Uterus*

Introduction

Unicornuate uterus with a rudimentary horn is the rarest congenital anatomic anomaly of the female genital system. A rudimentary horn usually develops following insufficient development of mullerian ducts. The frequency of congenital uterine anomalies in a fertile female population is about 1/200 to 1/600, whereas the frequency of rudimentary horn is 1/100 000 [1].

Case Report

This pt seen for the first time as a case of primary infertility, pelvic pain and irregular cycles Transvaginal ultrasound was done as part of pre-treatment investigation, but there was no comment on the uterine anomaly. The patient was diagnosed as case of infertility due to unovulation. She had been treated with clomiphene citrate and menogon injections.

On 28/02/17, she presented with missed period for 6 weeks with positive serum pregnancy test. Transvaginal ultrasound was done and showed left ectopic tubal pregnancy. The transvaginal ultrasound repeated on 01/03/2017 with a senior radiologist, who diagnosed the case as pregnancy in small left rudimentary horn with possibility of asymmetrical bicornuate uterus.

Laparoscopy decided to confirm the diagnosis and to remove the rudimentary horn, in order to avoid rupturing of the horn and to prevent life threatening bleeding.

For a financial reason the patient refused the laparoscopy in our hospital and went to another hospital where the ultrasound was repeated and they diagnosed the case as bicornuate uterus with pregnancy in one corn with a unicollis cavity. They planned the case for cerclage at 13 weeks. The patient convinced with diagnosis.

Laparoscopy discussed again with the patient along with the risk of life threatening bleeding and risk of ruptured horn, but the patient refused again.

She presented to our hospital at 15 weeks, cervical cerclage was already done in another hospital.

The ultrasound repeated showed normal growing fetus in a bicornuate uterus with a horn compressed posteriorly.

The pt continued her antenatal care in another hospital.

Presented back to our hospital at 27 weeks +2 days with an ultrasound report from another hospital reported as asymmetrical IUGR and she was on heparin and aspirin.

Dexamethasone inj administered to enhance lung maturity. Ultrasound repeated showed: BPD= 25 weeks, Fl = 22 weeks, AC = 23, BPP was 8/8.EFw = 629 gm.

Ultrasound Doppler study requested and Termination decided.

The pt did not accept the decision and did not come to complete her preparations and investigations (As she will deliver in another hospital).

On 06/08/17 I received a call from the resident on duty that the pt was brought to the emergency department because she fainted at home and lost her consciousness.

I ordered for resuscitation until my arrival and to prepare the patient for possible stat laparotomy as probably she ruptured the pregnant uterine horn.

On my arrival, the patient already started resuscitation, trendelenburg position, IV fluids. Blood cross matching already requested. The pt was hypotensive with weak pulse, tenderness all over the abdomen.

Bed side ultrasound showed ruptured left horn with the fetus floating in the upper abdomen and was bradycardic.

Laparotomy done immediately. The left horn was ruptured, the fetus delivered and admitted to NICU. The ruptured horn removed with the placenta inside along with the left tube by clamping and dividing a non-communicating fibro muscular band.

The patient transfused with 4 units of blood

The neonate died in NICU.

The pt discharged in the third post-operative day in good stable condition.

She conceived 9 months later and underwent an urgent caesarean section at 36 weeks (was breech presentation).

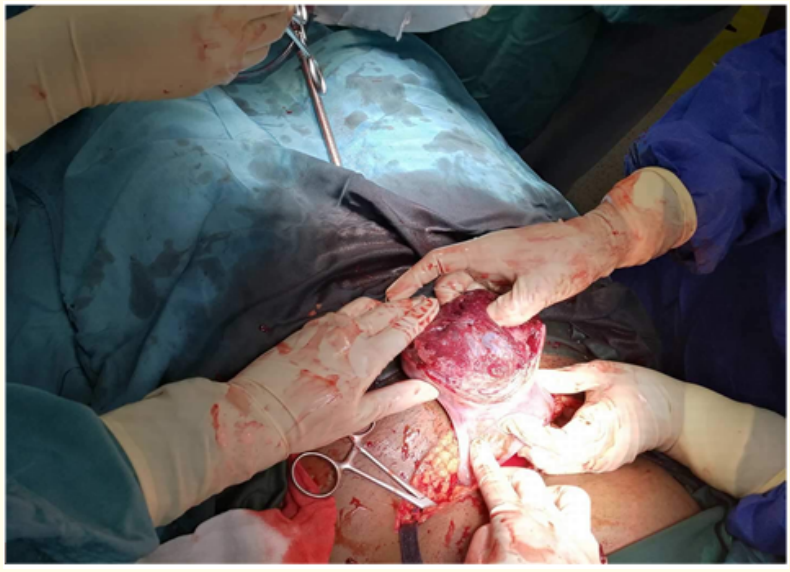

Figure 1: *The ruptured left horn connected to a non-communicating fibro muscular stalk.*

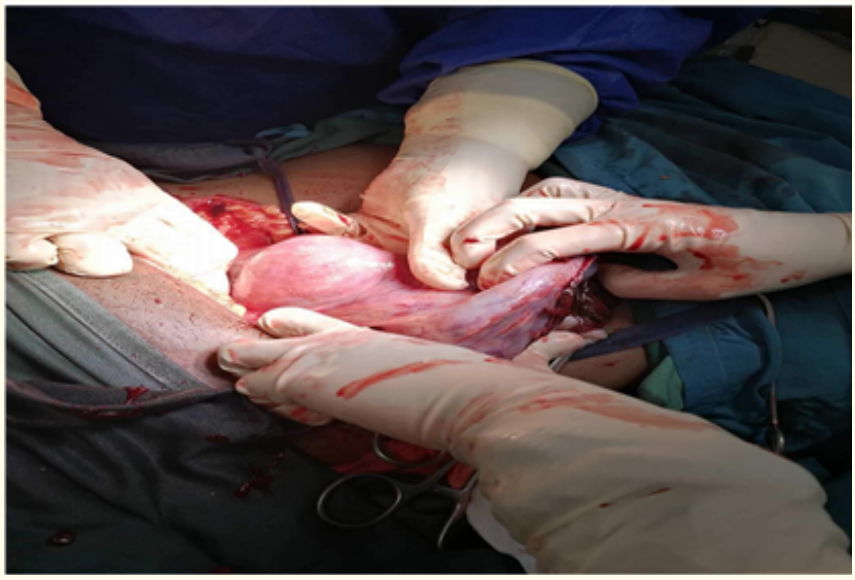

Figure 2: *The ruptured left horn and the right healthy uterus attached with a non-communicating fibro muscular stalk.*

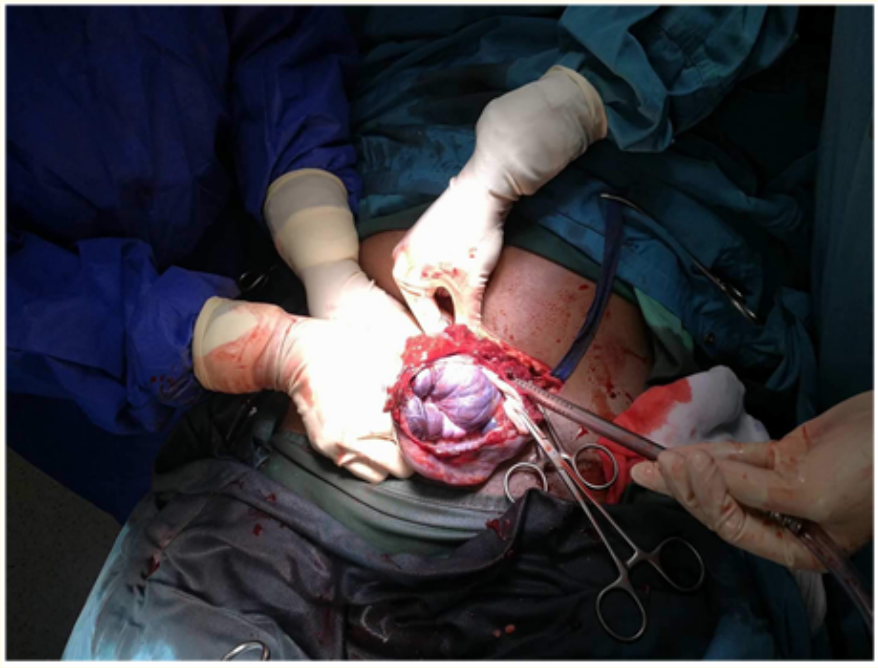

Figure 3: *The ruptured horn with the placenta still inside.*

Discussion

Unilateral hypoplasia of the mullerian duct is a congenital anomaly resulting from a rudimentary horn.

This developmental anomaly is classified according to its relation with the uterine cavity. The pathology is classified into 4 groups by the American Society of Reproductive Medicine (ASRM) as unicornuate uterus with communicating rudimentary horn, unicornuate uterus with noncommunicating rudimentary horn, isolated unicornuate uterus, and non-cavitated unicornuate uterus with noncommunicating rudimentary horn [1].

Rupture of pregnancy in rudimentary horn by second trimester is the most common outcome but silent rupture with continuation of pregnancy as secondary abdominal pregnancy was reported in some studies [2].

The treatment of non-communicating rudimentary horn with functional endometrium is excision of the horn either laparoscopically or by laparotomy to avoid the complications that may develop likes rupture of horn due to pregnancy and also endometriosis [3].

Conclusion

High clinical suspicion, early diagnosis, detailed patient history and timely laparotomy can reduce maternal mortality and morbidity.

Bibliography

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