

CASE REPORT

COMMUNICATING BICORNUATE UTERUS WITH DOUBLE CERVIX AND SEPTATE VAGINA : AN UNCOMMON MALFORMATION DIAGNOSED CLINICALLY AND BY USG

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Abstract

We report a case of communicating uterus characterized by a communicating tract between two separate uterine cavities.

Clinically we found double cervix & vaginal septum and by USG two separate horns. Clinically we could see the communication between two uterine cavities in supracervical portion during the process of abortion.

Pt advised MRI and HSG to confirm a diagnosis of 'type 4 a communicating uterus' according to Toaff classification which is rare abnormality.

Introduction

Communicating uteri are a distinct class of uterine malformations characterized by the presence of a communicating tract between two otherwise separate uterine cavities. This malformation was first identified by Musset in 1967. Then Musset and Leo Toaff¹ proposed a comprehensive classification of communicating uteri. Ten different groups of communicating uteri have been classified. Five of them are variant or subgroups.

This morphological classification is based on the constant presence of interhemian communication on the degree of separation of müllerian duct and their partial atresia.

In clinical practice these malformations are of the accidental finding because they do not affect patients clinical condition.

Therefore the American fertility society does not group them with other female genital tract anomalies.

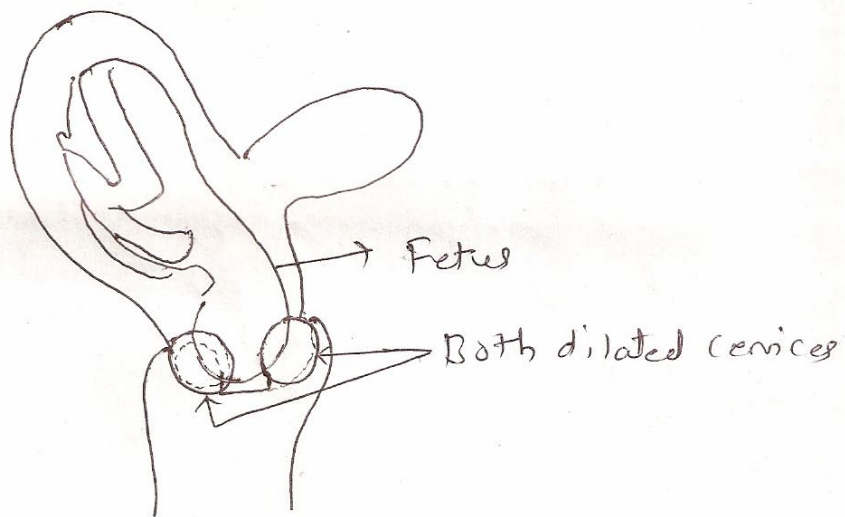
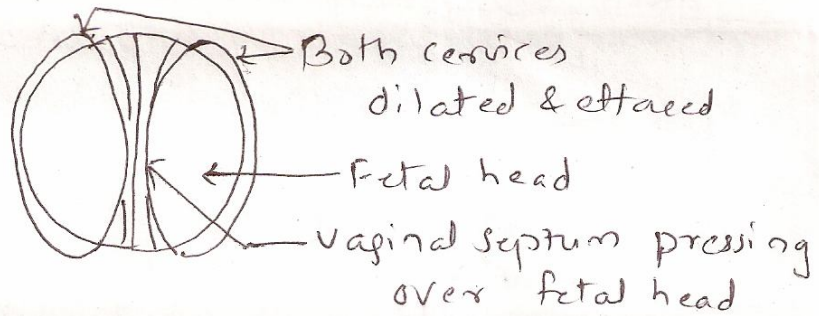
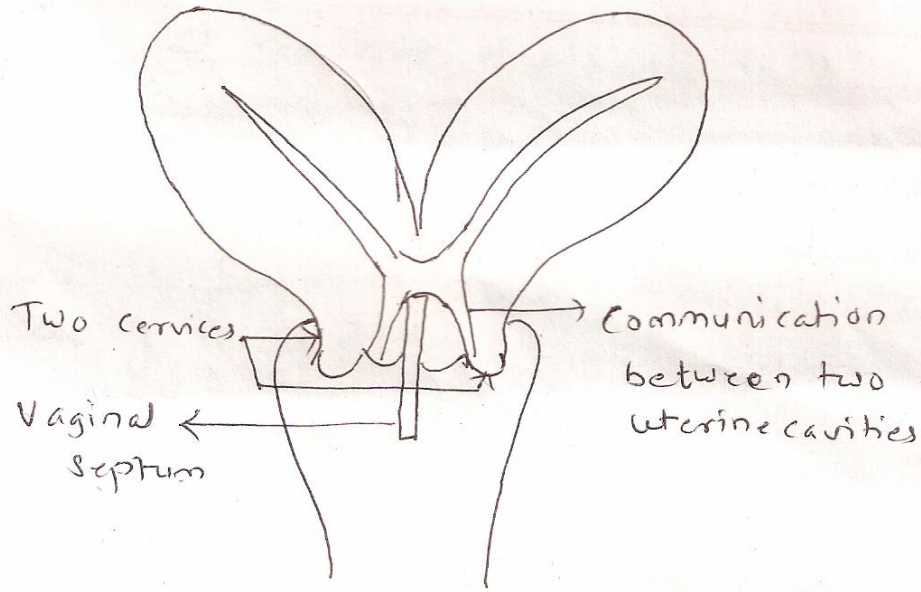
Case History

26 years second gravid referred to as with history of 5 ½ months amenorrhoea and complaints of pain in last 2 days clinically suggestive of inevitable abortion with non progression

Her previous menstrual cycles were regular with spasmodic type of dysmenorrhoea she gave obstetric history of full term LSCS for breach in 1st pregnancy Previous records were not available.

On admission her vitals were stable P/A examination revealed fundal height 22wks with good uterine contraction and absent fetal heart.

Per vaginal exam showed a longitudinal incomplete vaginal septum Fetal head was palpated on either side of septum through 3cm dilated both cervixes . septum was compressed by fetal head and seen as vertical band at the center & pressing over fetal head (considering history of previous LSCS We decided to remove baby under general Anaesthesia We had a choice of going through either cervix for the removal of baby Baby delivered through left cervix – by fundal Pressure Baby delivered easily after pushing septal band on Rt side. But placenta retained Injection prostaglandin & oxytocins given



Manual removal of placenta tried by inserting finger through cervix. But uterine cavity was empty. We were unable to find communicating tract, with the finger to reach placental site. Keeping in mind possibility of migration of placenta through a scar of previous LSCS into peritoneal cavity, we abandoned the procedure and we did ultrasound which revealed bicornuate uterus with retained placenta in right horn & empty left horn. With antibiotic coverage, Pt again taken for removal of placenta,

Now we went through right sided cervix. We would reach the placenta & remove it in piecemeal.

Postoperative recovery was uneventful.

Discussion

Mullerian duct anomalies occur in 1-0.5% of woman Among them, communicating uteri account for 1-2% of malformation.

communicating uteri are often an occasional findings during HSG usually performed for infertility or suspected malformation.

Here in our case, both cervixes were dilated & effaced felt like two separate rings. Longitudinal vaginal septum was pressing over the fetal head & was the cause of her Nonprogression.

We could deliver the baby through left cervix but Unable to remove placenta as that side of cavity was empty It means there was a presence of two separate uterine cavities with communication between two at supracervical region along with incomplete longitudinal septum.

The communication could be either at isthmic or mid cervical region it is very rare condition².

Confirmation is advised by HSG & MRI for which pt is yet to follow.

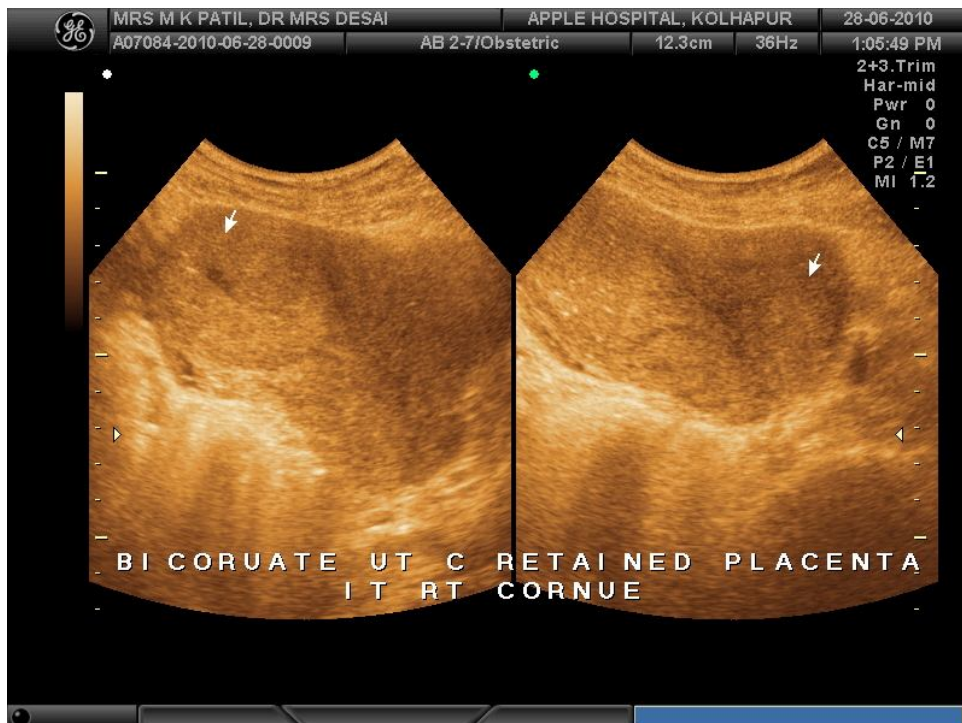
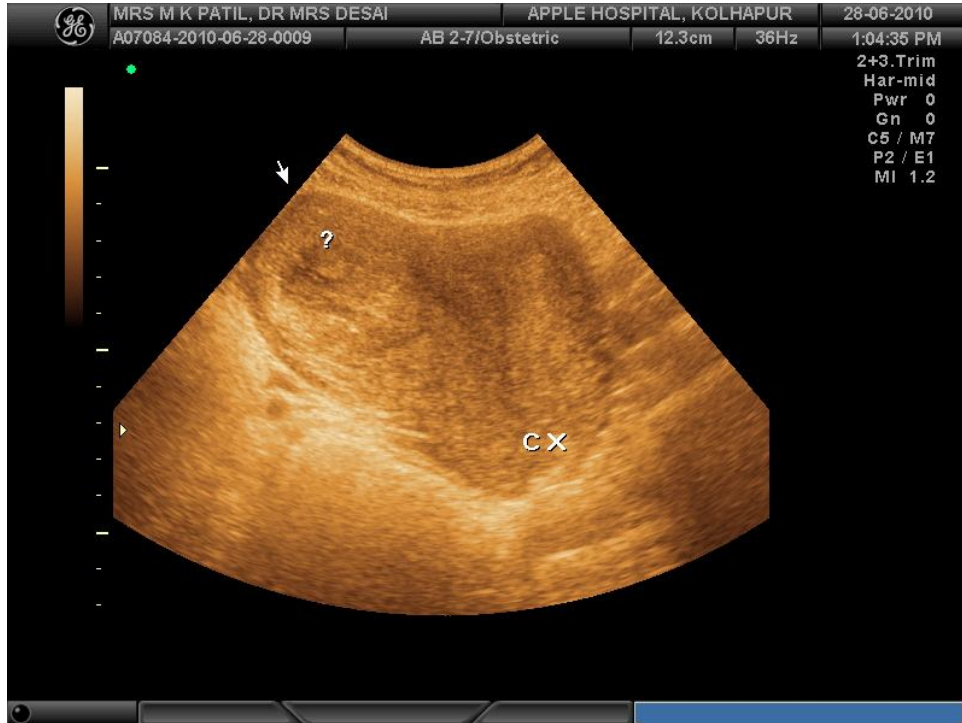
Conclusion

Mullerion duct anomalies are an uncommon but often tractable cause of infertility. Patients with Mullerian duct anomalies are known to have a higher incidence of infertility, repeated first, second trimester spontaneous abortions, intrauterine growth retardation, fetal malpositions, preterm labor & retained placenta.

Role of imaging is to help detect, diagnose and distinguish surgically correctable forms of Mullerian duct anomalies from inoperable forms.

In some correctable lesions, the surgical approach is entirely based on imaging findings.

Sonographic appearance of retained placenta in Right Horn of Bicornuate Uterus



Longitudinal Vaginal Septum



**Longitudinal Vaginal Septum with double
cervices seen on both side of Septum**



