Case Report

Hematometra in Uterus Didelphys with Right Hemivagina and Right Renal Agenesis

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Introduction

Developmental anomalies of the Mullerian Duct System are some of the more fascinating disorders encountered by obstetricians and gynecologists. Mullerian defects represent a broad spectrum of abnormalities ranging from uterine and vaginal agenesis to duplication of the uterus and vagina to minor uterine cavity abnormalities. They are frequently associated with abnormalities of the renal and axial skeletal system. The reported incidence rate varies widely from 0.2 to 7.4%¹. Didelphys uterus is a rare congenital anomaly and is composed of two separate normal sized uteri and endocervical canals with cervixes that are fused at the lower uterine segment. Obstructed unilateral vagina in patients with uterus didelphys is uncommon and is frequently associated with ipsilateral renal and ureter agenesis also known as Wunderlich-Herlyn-Werner Syndrome². Workup for these patients includes ultrasonography and /or hysterosalpingography. If these investigations are inconclusive then MRI and IVP need to be done³.

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Case Report

A 13-yr-old adolescent girl presented at Purandare Hospital with complaints of pain in the abdomen and scanty menses since six months, past MC-3-4/30. She gave history of excision of imperforate hymen for drainage of hematometra and hematoocolpos four months back. Transvaginal aspiration of hematometra subsequently was done in the following cycle. The patient was admitted on 20/02/2002. On examination the general condition was fair and P/A: no mass felt. External genitalia appeared normal; Hb-11 gm%, Urine-N, Creatinine-0.8%. USG showed hematometra (right), with bicornuate uterus with absent right kidney. IVP confirmed absence of right kidney. The patient was operated on 23/02/2002. EUA and diagnostic laparoscopy was scheduled. EUA revealed a single cervix and a 4x3" cystic to firm mass in the right fornix. On Laparoscopic examination a didelphys uterus was seen. Bilateral tubes and ovaries were normal. There was evidence of endometriosis in POD. Cavity of the left side horn which was communicating with cervix could be negotiated, where as right side was non communicating. There was spill present on left side.

There was a dilemma in planning the management. Whether unification of both uterine horns should be done or hysterectomy of the non communicating horn should be planned or the option of surgically communicating cervix with

Fig.1 Hematometra in right non communicating horn drained.

Fig.2 Right horn communicating with cervix and vagina with inflated foleys kept insitu.

vagina of the non communicating horn be undertaken?

On laparotomy at the Bombay Hospital, right side uterus opened up medially and hematometra was drained. Dilator was used to assess patency of the cervix. Fresh communication of the cervix with vagina was created by abdomino-vaginal approach. Vaginal space was dissected along the dilator. There was a longitudinal septum which was obstructing the cervical opening into the vagina which was dissected with the help of a dilator through the abdomino-vaginal route.

Foleys catheter was introduced from the vagina into the newly dilated cervix. Balloon inflated and uterus was closed in layers. Patency of right tube was confirmed. Foleys catheter was kept for seven days to keep the vagina patent. Since the dissected space opened into the existing vagina was wide, we did not need to use the mould for patency of vagina.

Post operative recovery was uneventful. Per speculum showed 2 cervical openings in the vagina. The patient was discharged on 03/03/2002. Follow up done for seven months. The patient had regular flow and no other complaints. Per speculum after seven months gave us the same picture of two cervixes opening into the patent vagina after which patient did not follow up. There was no recorded hematometra on the USG and menstrual flow was normal.

Conclusion:

The specific association of a uterus didelphys, an obstructed hemivagina, and an absent ipsilateral kidney

was first described by Wilson¹ in 1925. Since that time, the constellation of a uterus didelphys, an obstructed hemivagina, and sometimes an absent ipsilateral kidney has been reported as presenting with a concurrent cyclical vaginal mass¹⁻⁷, hematocolpos¹⁻⁸, a foul vaginal discharge^{2,3,9,10}, intermenstrual bleeding^{2,4,9}, acute abdominal pain^{2,5,7,8} and urinary symptoms⁴. Methods for resection of the transverse vaginal septum have been proposed, and successful term pregnancy after resection has been reported^{2,4,10}.

The introduction of 3D sonography for diagnosis of uterine anomalies may improve diagnostic accuracy. Salim et al¹¹ explored the reproducibility of 3D sonographic diagnosis of congenital uterine anomalies and found it to have acceptable reproducibility in both diagnosis and anomalies.

Mullerian duct Anomalies (MDA) are a morphologically diverse group of congenital disorders involving the female reproductive tract. A septate or a double vagina may occur in isolation if canalization of the most caudal part the fused mullerian duct is incomplete. Establishing an accurate diagnosis is essential for planning treatment and management strategies⁴. The surgical approach for correction of MDAs is specific to the type of malformation and may vary within a specific group. For most surgical procedures, the critical test is of the patient's postoperative ability to have healthy sexual relations and successful reproductive outcomes^{5,6,7}.

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