CASE REPORT

Pregnancy in Non-communicating Half of Septate Uterus

Chandra Madhuri · Pathak Varuna

Received: 17 March 2010 / Accepted: 23 June 2012 / Published online: 27 March 2013
© Federation of Obstetric & Gynecological Societies of India 2013

Introduction

Septate uterus is the most common structural anomaly of all mullerian defects. It is included in Class V of the AFS classification of anomalies of mullerian ducts.

Fusion of the median septum of the mullerian ducts proceeds cephalad from the mullerian tubercle up to the junction of future round ligaments; shortly thereafter, the septum between the ducts is resorbed. Congenital defects can occur because of failure of lateral fusion. If the two horns of the partially fused uterus are recognizable, the uterus is designated as a bicornuate uterus. However, if the external configuration of the uterus is relatively normal and malfusion is represented only by a septum within the uterus, the uterus can be referred to as a septate uterus.

A cornual pregnancy results from nidation in one horn of a bicornuate uterus, a unicornuate uterus, or in lateral half of a septate uterus, and is therefore not strictly an ectopic pregnancy.

Case Report

Patient RR, Para 1, was referred from Narsinghgarh as suffering from amenorrhea from the past 9 months, with failed induction of labor done for intrauterine fetal death. On P/A examination, an abdominal mass of 36 weeks' size was found; it was firm, hard, and tender, with fetal parts not made out and FHS negative. P/V Os 2 cm, the mass was to the right and posterior to the cervix; the uterine cavity appeared empty (Fig. 1).

On USG, the uterus was enlarged but empty and anterior to the sac, containing a single dead fetus of 33 weeks' gestation.

With a provisional diagnosis of secondary abdominal pregnancy, the patient was taken for laparotomy. On laparotomy, the lower segment of the uterus appeared externally normal; after reflecting bladder peritoneum, a nick was given in the lower segment extended by fingers and the baby was delivered—female, 1.5 kg, stillbirth. On exploration, there was no communication of cavity with the cervix. Therefore, a repeat per vaginum examination was done and it was realized that the examining fingers were passing through the cervix to the left of a septum completely dividing the uterus into a right pregnant half, which did not communicate with the cervix, and a left non-pregnant half, which communicated with the cervix (Fig. 2).

The uterus was repaired on both sides of the septum; the patient was advised tubal ligation on the right side, but she refused consent. The lower portion of the septum was

Chandra M., Associate Professor
Department of Obstetrics and Gynaecology,
Gandhi Medical College, Bhopal, India

Pathak V., Associate Professor
Department of Obstetrics and Gynaecology, Sultania Zanan Hospital,
Bhopal, India

Chandra M. (✉), Associate Professor
E-1/104 Arera Colony, Bhopal, MP 462016, India
e-mail: madhurichandra@bsnl.in

Fig. 1 Right horn pregnant, left horn non-pregnant

Fig. 2 Right non-communicating pregnant horn, left half communicates with cervix, thick septa between the two halves

Fig. 3 Uterus after repair, note the enlarged *right* side, tubes and ovaries on both sides are normal

excised and a drain from the right side of the uterus passing into the left half and then through the cervix into the vagina was left. We did not think any further septoplasty was possible in view of the pregnant status. Postoperatively, she was counseled for septum resection, but did not come for follow-up (Fig. 3).

Discussion

In this case, transperitoneal migration of sperms with fertilization and implantation in the non-communicating horn probably took place. Questions that need to be answered are why, on retrospective history taking, the patient admitted to only mild dysmenorrhea. The patient had one previous full-term vaginal delivery at home. The non-communicating half did not seem to have caused her any problems, either after menarche or by retained discharges in this pregnancy.

Presuming that the first pregnancy was in the left half, the right half must have become enlarged and the endometrium must have undergone decidualization.

About 0.25 % of fertile women have some form of mullerian duct abnormality. Robert's uterus, a septate uterus with two uterine cavities, one being blind, was first reported in 1970 [1, 2]. The present case is reported because of its rarity [3, 4], the pregnancy probably caused by transperitoneal migration of sperms and being carried to term.

References

1. Benzineb N, Bellasfar M, Merchaoui J, et al. Robert's uterus with menstrual retention in blind cavity. *J Gynecol Biol Reprod.* 1993;22:366–8.
2. Gupta N, Mittal S, Dadhwal V, et al. A unique congenital mullerian anomaly: Roberts uterus. *Arch Gynecol Obstet.* 2007; 276:641–3.
3. Singhal S, Agarwal U, Sharma D, et al. Pregnancy in asymmetric blind hemicavity of Robert's uterus. *Eur J Obstet Gynecol Reprod Biol.* 2003;107:93–5.
4. Singhal S, Sharma D, Choudhary P. Pregnancy in Robert's uterus. *J Obstet Gynecol India.* 2009;59:597–8.