RUPTURE OF GRAVID HORN OF BICORNUATE UTERUS (A Case Report)

Wg Cdr CD CHAWLA*, Sqn Ldr RK SAXENA+,
Dr (Mrs) CHANDRIKA MURALIDHAR#

MJAFI 1995; 51 : 138-139

KEY WORDS : Uterine rupture; Pregnancy complications.

Introduction

Pregnancy in the rudimentary horn of a bicornuate uterus is a rare condition. Johanson placed the incidence of rudimentary horn pregnancy at approximately 1 in 1,00,000 pregnancies [1].

This case is presented in view of the rarity of the condition and necessity of keeping this entity in differential diagnosis of acute abdomen in the second trimester of pregnancy.

CASE REPORT

A 25-year-old, unbooked, second gravida was admitted with history of amenorrhoea of 16 weeks and acute pain in abdomen of two hours duration. The sudden severe pain started in the umbilical region and then became a continuous dull ache all over the abdomen. She also vomited three times, and vomitus contained food particles. There was no history of hematemesis and there was no relief of pain after vomiting. There was no history of trauma, fever, loose motions, burning micturition, bleeding or discharge per vaginum. She gave no history of shoulder pain or fainting attacks.

Patient was second gravida with history of one spontaneous abortion at 12 weeks of gestation, a year ago. Dilatation and evacuation was done in a civil hospital and post-abortion period was uneventful. Her previous menstrual cycles were regular with normal flow. She was operated five years ago for renal calculus and pyelolithotomy was done on right side.

On examination, patient was pale, pulse 100/min regular, blood pressure 100/70 mm Hg. Tenderness over hypogastrium was present. There was no distension, rigidity or guarding. Clinically there was no shifting dullness. Bowel sounds were normal. Uterus was palpable per abdomen and was about 16 weeks size. Per vagum cervix was tubular, internal os closed, and cervical rocking was non-tender. There was no bleeding per

vaginum and no other mass was felt in fornices.

Baseline investigations done on admission were within normal limits. Hb - 10g%. Urine routine and microscopic examination was normal. Blood group was 'A' positive.

Patient's general condition deteriorated within an hour of admission as her pallor increased with pulse 116/min, regular, and blood pressure of 80/60 mm Hg. An urgent ultrasound scan of abdomen revealed free fluid in abdomen and a fetus corresponding to 16 weeks size in peritoneal cavity. Fetal heart activity was absent. Uterus was visualised separately from fetus.

An emergency laparotomy revealed a bicornuate uterus with fundal rupture of right horn and 16-week size dead fetus in abdominal cavity. Excision of right horn of uterus with its fallopian tube was done and abdomen was closed after peritoneal toilet. Postoperatively she was transfused three units of blood and she made an uneventful recovery. Patient was discharged on tenth post-operative day. Follow up hysterosalpingography done after 6 weeks revealed a unicornuate uterus with patent fallopian tube.

Discussion

The myometrium of the rudimentary horn is usually poorly developed and the time of the rupture depends upon the degree to which the myometrium can grow in response to the pregnancy. In a review of 327 rudimentary horn gestation, O'Leary noted that 89% of these uteri had ruptured by the end of second trimester [2]. Pregnancy in rudimentary horn is associated with a mortality rate as high as 5% [1].

The most common presentation of pregnancy in rudimentary horn is abdominal pain. The pain may occur after or before

* Reader, Dept of Obstetrics & Gynae, AFMC, Pune 411040; +Graded Specialist, #Post-graduate Student, Dept of Obstetrics & Gynae, Command Hospital Air Force, Bangalore.

rupture. Diagnosis of rudimentary horn is usually made at laparotomy [3].

The accepted treatment is to remove the gravid rudimentary horn and leave the normal one behind to function as regards menstruation and reproduction. Where removal of rudimentary horn is not possible, a total hysterectomy has to be performed [4].

Increased awareness leading to a heightened index of suspicion of these rare conditions will lead to further decrease in morbid-

ity and mortality.

REFERENCES

1. Johansen K. Pregnancy in a rudimentary horn, two case reports. *Obstet Gynecol* 1969; 34 : 805.
2. O'Leary JL, O'Leary JA. Rudimentary horn pregnancy. *Obstet Gynecol* 1963; 22 : 371.
3. Romaine BB. Non tubal ectopic pregnancy. *Clinical Obstet Gynecol* 1987; 30.
4. Myerscough PR. *Munro Kerr's Operative Obstetrics* 9th edition, New York : Macmillan Publishing Co Inc. 1977; 649-96.