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CASE REPORT

BICORNUATE UNICOLLIS UTERUS; AN INCIDENTAL FINDING IN PERIMENOPAUSAL WOMAN: A CASE REPORT

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ABSTRACT

Bicornuate uterus is a rare type of congenital Müllerian duct malformation, formed due to failure of fusion of upper part of Müllerian duct during embryogenesis. Incidence of congenital uterine malformations is 0.1%-3%, of which incidence of bicornuate uterus is 25%. Mostly bicornuate Uterus is asymptomatic in presentation. However in symptomatic cases, it presents with early pregnancy loss, labour dystocia and gynaecological problems such as abnormal uterine bleeding and dysmenorrhea. Authors here describe a case of bicornuate uterus found incidentally in a 45 year old woman with history of three uneventful vaginal deliveries, who underwent hysterectomy with complaints of abnormal uterine bleeding and fibroid uterus. Hence emphasizing that asymptomatic Müllerian anomalies diagnosed incidentally in any age group should not raise a concern & treatment should be aimed only when they are symptomatic.

INTRODUCTION

Bicornuate uterus commonly referred as "heart shaped uterus" is a type of congenital Müllerian duct malformation, characterised by two uterine horns separated by a septum. It is formed due to failure of fusion of upper part of Müllerian duct during embryogenesis. Incidence of congenital uterine malformations is 0.1%-3%, of which incidence of bicornuate uterus is 25%[1,2]. It is of two types:

- Bicornuate bicollis: two uterine horns with two cervical canal respectively.
- Bicornuate unicollis: two uterine horns with single cervical canal.

Mostly bicornuate Uterus is asymptomatic in presentation and found incidentally. However in symptomatic cases, it presents with early pregnancy loss, preterm delivery, fetal growth restriction, fetal malpresentations, retained placenta, labour dystocia and gynaecological problems such as abnormal uterine bleeding and dysmenorrhea[3].

Authors here describe a case of bicornuate uterus found incidentally in a 45 year old woman who underwent hysterectomy with complaints of abnormal uterine bleeding and fibroid uterus.

CASE REPORT

A 42 year old woman presented to gynaecology outpatient department with complaints of irregular cycles and heavy menstrual bleeding since four months. Her previous cycles were regular; occur at interval of 28-30 days, lasting for 3-5 days with average blood flow. However since last four months, she was having heavy bleeding lasting for 8-10 days, occurring at interval of 15-20 days and associated with dysmenorrhea. Her obstetric history was parity 3 with 3 live issues. All deliveries were normal vaginal delivery at home. Her last child birth was 14 years ago. On examination, her vitals were stable. On per speculum examination, cervix and vagina was healthy. On per Vaginum examination, uterus was anteverted, enlarged in size up to 8-10 weeks and bilateral fornices were free.

On investigations, blood investigations were normal. On ultrasonography, two uterine horns with two separate endometrial cavities were visualised without any communication suggestive of bicornuate uterus (figure I).

Patient was started on medical management but she did not respond to that for which patient was taken for hysterectomy. On gross examination two uterine horns were seen lying separately, each having its own endometrial cavity, which was non-communicating to each other. One uterine horn was larger than other of size 9 × 4 × 3 cm with an intramural fibroid of size 4 × 3 cm. Other uterine horn was of size 7 × 3 × 2 cm.

Both horns were connected to single cervical cavity of length approximately 3 cm (figure II).

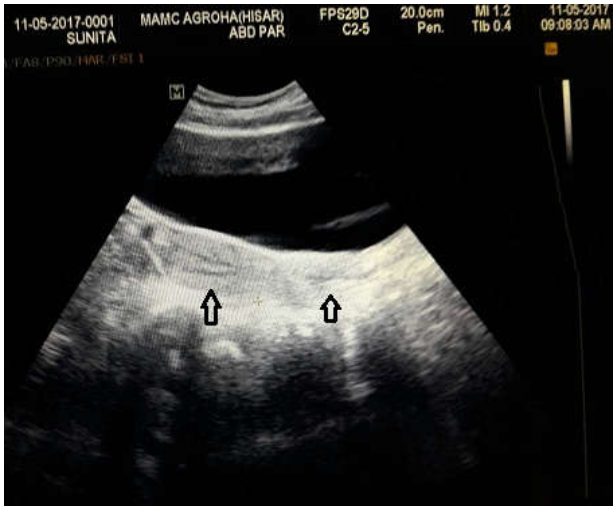

Figure I an ultrasound image showing bicornuate horns with two uterine horns.

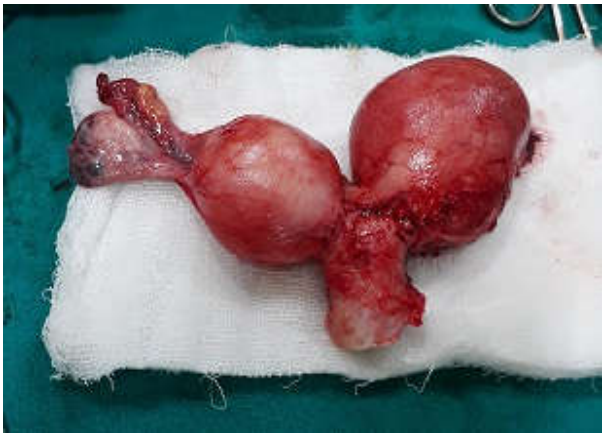

Figure II specimen showing bicornuate uterus with two uterine horns, one larger than other and single cervical canal.

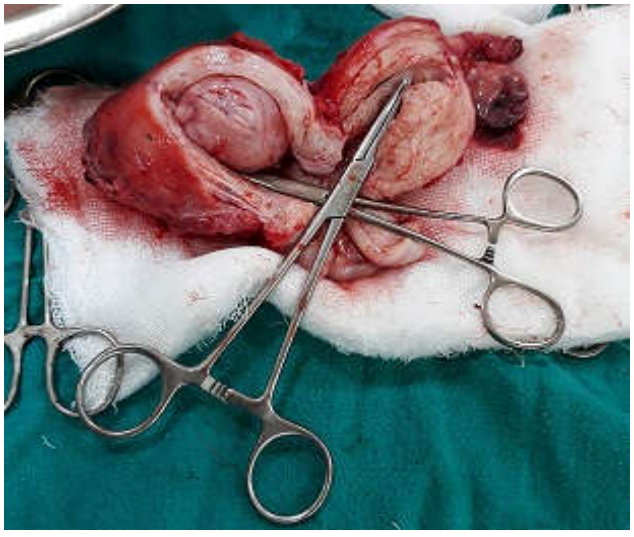

Figure III specimen showing bicornuate uterus with two non communication uterine horns, each communicating separately with single cervical canal and one enlarged horn with fibroid uterus.

DISCUSSION

Female genital tract develops from the Müllerian ducts between 6th and 12th week of gestation[2]. Normal development of female genital tract comprises of three phases – organogenesis, fusion and septal resorption. Defects in any of these three phases results in Müllerian duct anomalies. American society of reproductive medicine, in 1989 has classified uterine anomalies into seven classes as shown in Figure IV[4]. Bicornuate uterus occurs due to failure of fusion of upper part of Müllerian ducts. In our case the patient had bicornuate uterus which is classified as class IV uterine anomaly.

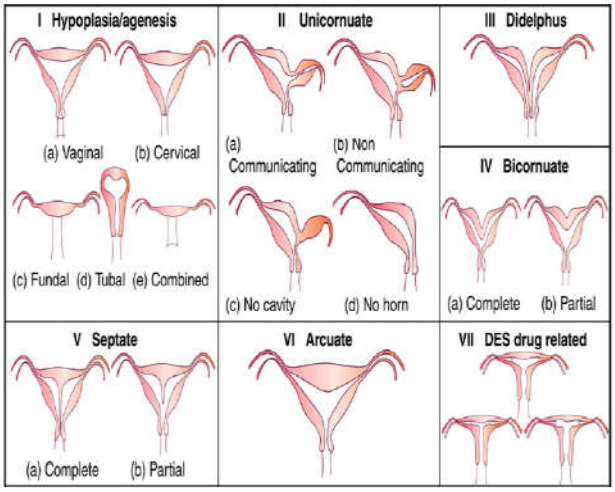

Figure IV Müllerian duct malformations according to classification by American society of reproductive medicine, 1989.

Uterine anomalies usually present with infertility and pregnancy associated complications such as early pregnancy loss, fetal growth restriction, fetal malpresentations, preterm delivery and retained placenta.

Bicornuate uterus is usually an incidental finding. However in symptomatic cases, it most commonly presents with spontaneous first trimester abortion. It occurs due to thin and weak muscle fibres which are arranged irregularly and relatively avascular[5,6,7].

Another fatal complication of pregnancy in one of the horns of a bicornuate uterus is uterine rupture, which occurs due to inability of malformed uterus to expand during pregnancy[6].

CONCLUSION

Authors here have described a case of a woman with bicornuate uterus who did not have any difficulty in conception or complications during pregnancy, hence emphasizing that asymptomatic Müllerian anomalies diagnosed incidentally in any age group should not raise a concern & treatment should be aimed only when they are symptomatic.

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