

BICORNUATE UTERUS WITH ATRESIA OF THE ENDOCERVICAL CANAL: CASE REPORT OF SUCCESSFUL METROPLASTY

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Keywords: Bicornuate uterus, congenital anomaly, Metroplasty

CASE

A 19 year old unmarried female patient with primary amenorrhea presented with cyclic abdominal pain on 16 May 2010 at gynecology department, Kesar SAL medical college & research institute, Ahmedabad. Her secondary sexual characters were normal. Per abdominal examination was normal. On per-rectal examination her uterus, vagina seemed of normal size and length. On Ultrasound of abdomen and pelvis, bicornuate uterus with single cervix (unicollis) with two separate horns was seen. Kidneys and other viscera were normal.

On examination under anaesthesia vagina seemed cribriform in appearance. A passage was created by putting multiple cruciate incisions; cervix could be visualized and mucus plug was removed. For further evaluation of the case, thorough investigations were done.

Her hormonal (FSH, LH and prolactin) levels were normal. Chromosomal analysis was of normal female genotype. Later diagnostic laparoscopic was done. Bicornuate uterus with non-communicating horns with intervening recto-vesical septum was seen. Right ovary had 3 cm x 2cm had chocolate cyst; about 20 ml of blood was sucked from pouch of douglas.

Strassmans' Metroplasty (unification of uterus)¹ was done after due pre-operative preparation on 5th June 2010. On laprotomy two separate horns of uterus were seen. Right horn was 5×3×2 cm and the left horn was 4×3×2 in size (Figure 1).

Both were incised at medial border, endometrium was exposed. Per vaginally, attempts to create passage between uterus and

cervix were done with the help of Hegar dilator no. 5.



Figure 1: Bicornuate Uterus with two separate horns with intervening septum between two horns



Figure 2: Unification of uterus and creating of communication between endocervical canal and the uterine cavity

However, attempts were unsuccessful. Abdominally intervening septum was incised

and dilator passed through it. Red rubber catheter was kept in situ to maintain the patency and myometrium was sutured around it in three layers with vicryl no.1 (Figure 2).

Chocolate cyst was incised. Hemostasis was achieved. Abdomen was closed. On 5th day red rubber catheter was expelled by itself. Cu T 200 was inserted to maintain patency. Tablet Premarin (conjugated estrogen) (0.625mg) once daily was started for 21 days. Follow up ultrasound showed uterus of 5cm in length and cervix was 2.5cm. Triple lined endometrium of 11 mm size was seen with Cu T in situ. Patient was reassured and Tablet Meprate (medroxyprogesterone acetate) 10mg once daily for 10 days was started. On 47th day she menstruated normally for 5 days. On follow up examination Cu T threads could be seen in situ.

DISCUSSION

The incidence of uterine congenital anomalies is approximately 1 in 200 out of which bicornuate uterus is the most common (about 45%).¹⁻³ Congenital anomalies of lateral fusion (uterus) of mullerian duct normally do not co-exist along with anomalies of vertical fusion (cervix or vagina). So atresia of endocervical canal with bicornuate uterus is a rare entity.^{4,5}

In Indian setup such patients present at a late stage after many complications. They are psychologically immature and most of the times they are non compliant. Thus they require sympathetic handling by the gynaecologist. Patient may present with hematometra or endometrioses due to the functioning

endometrium and cryptomenorrhoea due to cervical lumen atresia.⁶ Confirmatory diagnosis of such condition can only be done by combination of clinical examination, sonography as well as diagnostic laparoscopy.⁴

In most of the cases the treating gynecologist is tempted to go for hysterectomy due to already existing complication like haematometra and endometriosis. But it is possible to go for unification operation (metroplasty) along with creation of passage through atretic lumen of cervix, thus restoring the normal menstrual function.⁶⁻⁸ This can be a great benefit for the patient emotionally and psychologically.

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