UTERUS DIDELPHYS ASSOCIATED WITH GOOD PREGNANCY OUTCOMES AND AN ECTOPC KIDNEY(CASE REPORT).

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ABSTRACT:

The case of a 32year old para 3^{+0}, 3 alive with 3 years history of recurrent severe lower abdominal pain is presented. The pain was worse during her monthly cycles and relieved during pregnancy. Ultrasound showed a left ill defined adnexal mass with no kidney seen on the left. An impression of a symptomatic pelvic kidney was made. Laparotomy done showed a left pelvic kidney and a uterus didelphys. The second uterus was bulky and filled with menstrual fluid. She had a hysterectomy of the aberrant uterus. Uterus didelphys is usually rare and is associated with recurrent pregnancy losses.

This patient had normal pregnancy outcome three times.

The rarity of this condition and its association with an ectopic kidney prompted us to make this report. The need to look out for congenital anomalies of the genital tract associated with congenital anomalies of the kidneys is also stressed.

***Key words**: Full term pregnancy, Uterus didelphys, Laparotomy, Ectopic kidney.*

INTRODUCTION

The exact incidence of congenital genital tract abnormalities is unknown.[1,2.]

It is estimated that about one in 200 to 400 women have some minor or major degree of genital tract abnormalities[1.] Uterus didelphys is a classic example of failure of fusion of the Mullerian ducts in which there is complete duplication of the internal genitalia resulting in a double uterus (Septate) vagina, two cervices and two hemiuteri[1].

Among anomalies of the genital tract, failure of fusion of the mullerian ducts is commoner than failure of formation of the Mullerian ducts, failure of dissolution of the septum between the fused ducts and failure of the structures to disappear[1,3].

Minor degrees of abnormality involving uterine shape can be demonstrated in 10% of fertile women[1,2,3.]

The Mullerian and Wolfian ducts are so closely linked embryologically that gross malformation of the uterus and vagina are commonly associated with congenital anomalies of the kidney and ureter[1,2].

The case report is predicated on the rarity of this uterus didelphys, the fact that this patient had full term pregnancy three times without complications, and the rarity of the association of uterus didelphys with an ectopic kidney.

CASE REPORT

Mrs. K H was a 32 year Para 3+0, 3 alive. She first presented to the urological surgeon with recurrent lower abdominal pain of 3 years duration. Ultrasound showed no kidney on the left with an ill defined left adnexal mass suspected to be an ectopic pelvic kidney. A combined laporotomy was done by the urologist and gynaecologist because of the severe lower abdominal pain. This revealed a double uterus each with a fallopian tube and ovary attached.(See Figs I,II and III). The left uterus was bigger than the right and filled with menstrual effluent. She had hysterectomy of the left hemiuterus. (See Fig. IV)

The patient also had a left pelvic kidney which was left alone and patient was asked to do an intravenous urogram to ascertain kidney function before any intervention, however patient was lost to follow up.

DISCUSSION:

Full term pregnancies have occurred in patients with forms of bicornuate uterus and uterus didelphys, therefore true prevalence may be slightly higher than currently estimated [1.]

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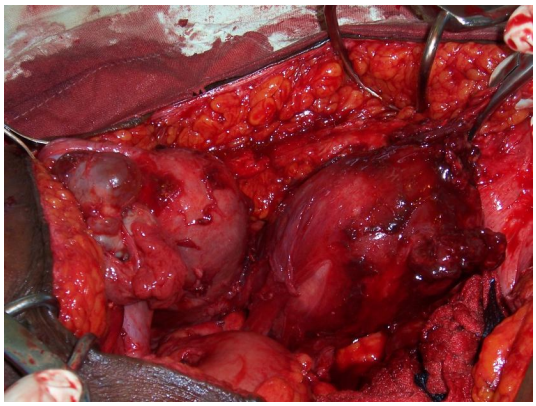


Fig I. Uterus didelphys each with single fallopian tube and ovary

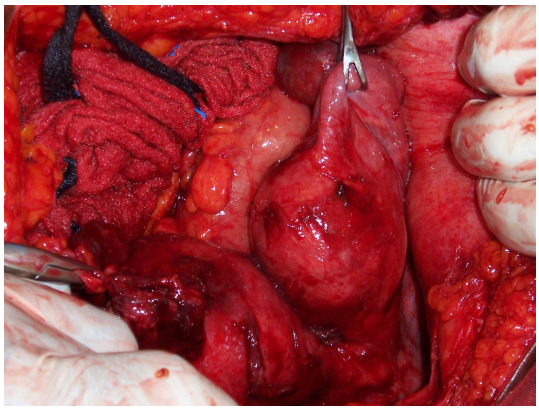


Fig II. Double uterus meeting at the vagina

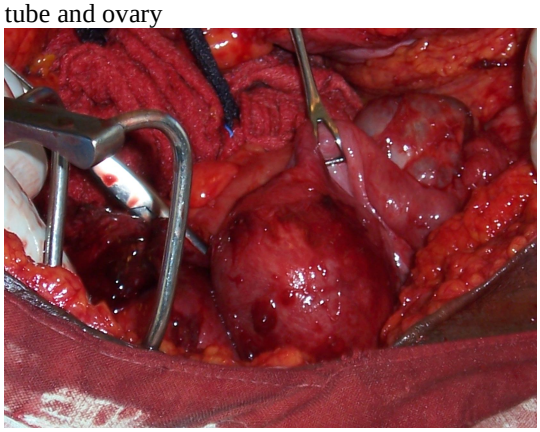
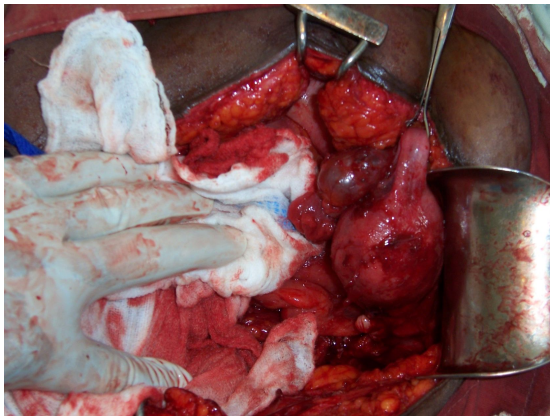


Fig III .Two hemiuteri, right ovary showing ripe follicle



FigIV. After excision of the left hemiuterus, stump in situ.

Most Mullerian ducts fusion anomalies are often symptomless with the vast majority being recognized during pregnancy or as a result of recurrent pregnancy loss. In this case, the patient carried her three pregnancies to full term without complications. She however had severe dysmenorrhoea outside of pregnancy because of failure of canalization of the second hemiuterus cervix. The pain subsided each time non steroidal anti-inflammatory drugs were administered and so the diagnosis was missed for a long period. Investigations for lower abdominal pain and failure to see the left kidney on ultrasound scan gave a suspicion of an ectopic pelvic kidney.

At laparotomy, a double uterus was seen, each hemiuteri had a single fallopian tube and ovary. Figs I & II. The left kidney was not located in the left lumbar region but in the midline of the true pelvis. She therefore had hysterectomy of the left hemiuterus (which was bulky and filled with menstrual effluent) since she was still desirous of fertility. She had normal postoperative recovery but could not do the intravenous urogram prescribed and was lost to follow up.

The diagnosis of uterine anomalies can easily be made by a combination of Hysterosalpingography, laparoscopy and real time b-mode ultrasound[2, 6]. Although uterine anomalies occur in only 0.1-0.5% of females in general, the incidence is from 48-70% in women with congenital renal anomalies[2 4,5] Each case requires separate consideration, though many could be left untreated.

This case had hysterectomy of the left hemiuterus because of the severe abdominal pain consequent upon the accumulated menstrual effluent. Bicornuateor septate uterus causing recurrent abortions needs a plastic operation (metroplasty) [1,3,6,7,8]. It is possible that this patient could conceive and carry pregnancy to full term like the others despite the surgery[8].

We conclude from our finding, not to intervene on structural anomalies of the uterus if they remain asymptomatic, as reproductive functions can still be achieved as with this case.

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