Case Report

Ruptured rudimentary horn pregnancy: A case report

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Abstract

True incidence of uterine anomalies is not known. Mullerian duct anomalies occur in 2-3% of all women but can be as high as 10–15% while the incidence of unicornuate uterus is 0.4%. Unicornuate uterus with Rudimentary horn is found when one mullerian duct fails to elongate while other develops normally. In class II American Fertility society Classification Unicornuate uterus associated with horn is divided into communicating and non - communicating type. Although the percentage of Rudimentary horn pregnancy is rare, the risk of maternal morbidity & mortality is high.
Key Words: Mullerian duct anomalie, rudimentary horn of uterus, laparotomy.

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CASE REPORT

A 30 yrs old Gravida 3 Para 2 Living 2 (G3P2L2) presented in OPD with complaints of 3 and half months amenorrhoea with acute pain in abdomen of 2 hrs duration and vomiting since morning on same day. Abdominal pain was severe variety, along with 2 episodes of vomiting and associated diziness. Patient was immediately taken for examination with her pulse rate of 100/min, BP 110 / 70 mmHg. Abdomen was minimally distended with generalized tenderness and ? uterus of 12 – 14 weeks size. On per vaginal exam there was no bleeding and exact size of uterus and mobility could not be made out. Diagnosis of acute abdomen was made and patient was immediately shifted to recovery room. While shifting to recovery room patient collapsed due to severe abdominal pain, and immediately I.V line was established. Her Vitals were re-checked which showed P-120/min low volume, Bp – 90/ 60 mmHg. P/A-tenderness increased, patient started looking very pale. An urgent bed side USG was done after reviving the patient which showed slightly bulky uterus with no intrauterine pregnancy and plenty of fluid collection around the uterus, further abdominal USG revealed a live fetus around 13 weeks lying away from the uterus with intact gestational sac. A diagnosis of ruptured uterus was made. An immediate arrangement of 3 pints of Whole blood was done. With counseling and High risk consent an Exploratory Laparotomy was done under Spinal Anaesthesia. Finding showed Hemoperitoneum on opening the abdomen. Plenty of blood clots were removed. Fetus with intact gestational sac of 14 weeks size as shown in (Fig 1) was removed from abdominal cavity.

Figure 1: Showing amputed rudimentary horn of uterus with 14 weeks size fetus with membranes intact

Uterus was delivered out through the incision which showed normal size Unicornuate uterus with Ruptured Rudimentary Horn along with Placenta on left side (as

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shown in Fig 2), suggestive of communicating rudimentary horn of uterus on the left.

Figure 2: Ruptured rudimentary horn of uterus with placenta

Decision of removing the Rudimentary horn was immediately taken and was removed. Hemostasis achieved. Patient was left with a Unicornuate Uterus of around 10 weeks size with a single fallopian tube and ovaries. Patients condition was stabilized by giving I.Vfluids and transfusing 3 pints of fresh whole blood. Postoperative stay was uneventful. The patient and her relatives were counseled about operative findings and cautioned not to have further pregnancy.

Histo-Pathology Report: Specimen removed measured 60 x 40 mm size uterine horn and a fetus of approximately 14- 16 weeks size. Cross section showed placenta with normal villi, few endometrial glands and stroma with muscle layer. The findings were considerate with rudimentary horn pregnancy.

DISCUSSION

This case report highlights the need for high level of suspicion of this rare complication of pregnancy [5]. Pregnancy in rudimentary horn cannot be saved and needs to be removed to prevent potentially fatal complication (rupture of horn of uterus.) This Patient had one ANC done prior to this episode. With previous history of two full term normal delivery suspicion of rudimentary horn pregnancy was unlikely. Diagnosis of uterine rupture though unlikely at 12 – 14 weeks was still made after considering the signs and symptoms with USG guidance as narrated in case report. There were no MTP or DNC done till her present Obstetric career. Obstetrics is tricky with emergency presenting at any juncture of time. As this patient, who deteriorated within no time, resuscitative measures present at time were appropriate with setting of two I.V line on both hands with I.V Fluids and Haemaccel going simultaneously to buy time for Ultrasonography and arrangement for whole Blood after USG diagnosis. Patient was then catheterised with self retaining Foleys catheter. A point of Tubal ligation though kept in mind but was not done considering emergency for patients life and also National Programme. As narrated in case history this patient was managed with a team effort.. The Sonologist, Anaesthetist, Obstetrician team, The staff members etc. Susequent Story :- Inspite of counseling and cautioning the patient and its relatives about the present outcome of patient and condition, patient still had a pregnancy after one and half year of this Laparotomy and had a Full term normal delivery at a government hospital which was uneventful

CONCLUSION

Ultrsound in first trimester is always recommended for such cases and along with number of fetuses with viability[1]. Blood investigation in first visit is equally essential[2]. Despite Advances in Ultrasound and other diagnostic modalities Pre natal diagnosis remains elusive with confirmatory diagnosis being done by Laparotomy. The diagnosis can be missed in the ultrasound especially in inexperienced hands. Precious time may be lost due to delay in diagnosis or misdiagnosis and general condition of patient may worsen as in our case[1]. Timely resuscitation, surgery and blood transfusion are needed to save the patient's life.

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