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Spontaneous Rupture of Left Horn of Uterus Didelphys during Mid-Pregnancy: A Case Report

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Abstract | **Case Report**

Uterus didelphys is one of the rare uterine anomalies. It results in various complications during pregnancy and delivery. A rare case of second gravida with one living issue, who presented with Spontaneous Rupture of Left Horn of Uterus Didelphys during Mid-Pregnancy with gross hemoperitoneum and shock. She was managed with prompt resuscitation, emergency laparotomy, repair of uterine rent along with tubal ligation and adequate blood transfusion. She was discharged from hospital.

Keywords: Uterus didelphys, Rupture of uterus, Hemoperitoneum, Shock, Uterine anomaly.

INTRODUCTION

Mullerian duct anomalies (MDAs) are congenital defects of the female genital system that arise from abnormal embryological development of the Mullerian ducts. These abnormalities can include failure of development, fusion, canalization, or reabsorption, which normally occurs between 6 and 22 weeks in utero [1]. Most sources estimate an incidence of these abnormalities to be from 0.5 to 5.0% in the general population. It is generally accepted that having a uterine anomaly is associated with poorer pregnancy outcomes such as increased chances of spontaneous abortion, premature labour, caesarean delivery due to breech presentation, and decreased live births, compared to a normal uterus. However, the degree of these outcomes varies among different types of uterine anomalies [2]. In this case report, we discuss a rare case of didelphys uterus rupture in a woman with a history of previous full term normal delivery. Uterus didelphys occurs because of abnormal fusion of the paramesonephric ducts and is characterized by complete duplication of uterine horns, cervix and very often also the vagina or presence of longitudinal vaginal septum.

CASE REPORT

24-year-old patient was referred from outside hospital with G2P1L1 (Previous Full term normal delivery) with 18 weeks of gestational age with USG S/O? Abdominal ectopic pregnancy with moderate hemo-peritoneum. Single dead extra- uterine foetus in infra umbilical region and placenta was noted in pelvic region Uterus appeared empty measuring 9.2 x5.5 x 5.3cms. She was vitally unstable with blood pressure of 90/60 mm Hg. Her pulse rate was 120/min low volume, SpO2 was 84% on room air. Five litres of oxygen was connected immediately to maintain her SpO2 up to 98%, on examination abdomen was distended and tender. Lab reports suggestive of severe anaemia. (Hb -4.8 grams%). Non-pneumatic anti shock garment (NASG) was applied before shifting the patient to OT for Exploratory laparotomy under general anaesthesia. Intra operative findings revealed a dead foetus which was found in the abdominal cavity. Didelphys uterus with ruptured lateral wall of left horn of uterus, Moderate hemoperitoneum was noted. Repair of the lateral wall of the left horn of uterus was done, both ovaries and fallopian tubes appeared normal. Bilateral tubal ligation was done. Three units of packed cell transfusion was given. Patient was then shifted to ICU for further management and discharged after complete recovery.

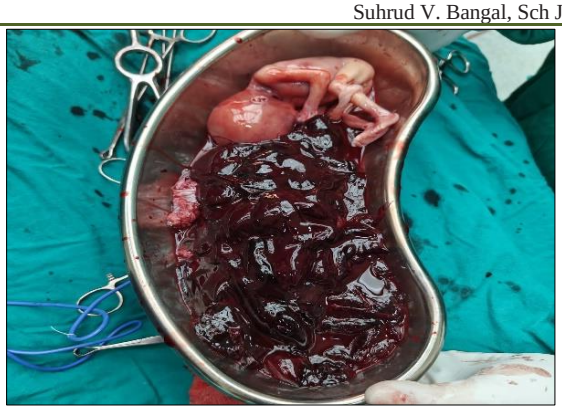

Fig.1: Showing Blood clots with fetus

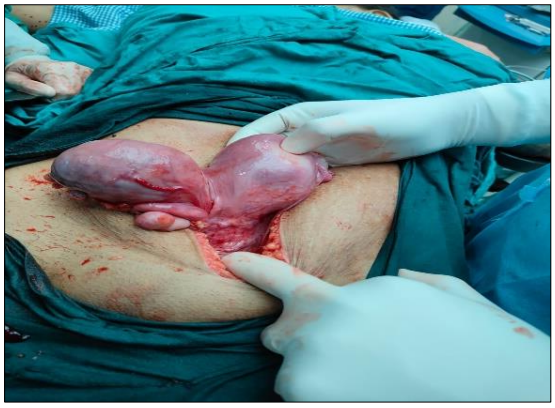

Fig. 2: Showing Uterus didelphys

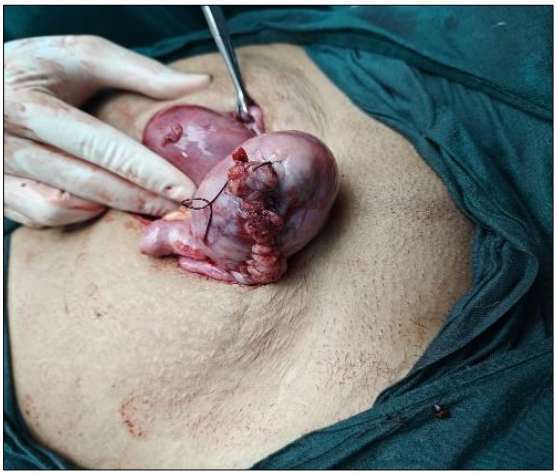

Fig. 3: Showing Uterus Didelphys with repair of rent of the ruptured horn at laparotomy

DISCUSSION

According to one estimate, didelphys uterus occurs in 0.1 to 0.5% healthy fertile population. The double uterus (didelphys) has a poor reproductive outcome with a 20 to 30% chance of carrying pregnancy to term. Normal pregnancies can occur in patients with mullerian duct anomalies, but obstetric complications such as spontaneous abortion, stillbirth and preterm birth are frequent. Didelphys uterus should always be considered in cases of severe dysmenorrhea and chronic pelvic pain; of the failure of intrauterine contraceptive devices; of a symptomatic or asymptomatic pelvic mass that is inseparable from the uterus. Most women with a didelphys uterus are asymptomatic but may present with dyspareunia or dysmenorrhea in the presence of a thick, sometimes obstructing, vaginal septum. This obstructing vaginal septum can lead to hematocolpos/ hematometrocolpos and thus present as chronic abdominal pain as well. Rarely, genital neoplasms and endometriosis are reported in association with cases of didelphys uterus. The fertility of women with untreated didelphys uterus has been shown by some sources to be better than those with other Mullerian duct abnormalities but still less than women with normal uterine anatomy. There is also an increased risk of spontaneous abortion,

foetal growth retardation, and prematurity with an estimated 45% (or lower) chance of carrying a pregnancy to term in comparison to a normal uterus. This indicates poor reproductive performance, but still not as poor as a septate or bicornuate uterus which are more common amongst the MDAs [3].

The prevalence of uterine anomalies in the general population was one in 201 women (0.50%). Their distribution was 7% arcuate, 34% septate, 39% bicornuate, 11% didelphic, 5% unicorn ate, and 4% hypoplastic/aplastic/solid and other forms. In such cases, the walls of the abnormal uteri tend to become abnormally thin as pregnancies advance, and the thickness can be inconsistent over different aspects of the myometrium [4]. Ravasia *et al*., reported an 8% incidence of uterine rupture (2 of 25) in women with congenitally malformed uteri compared with 0.61% (11 of 1,788) in those with normal uteri ($p = 0.013$) who were attempting VBAC [5].

CONCLUSION

The didelphys uterus is a very rare Mullerian duct anomaly with varying reproductive and gestational outcomes in comparison to other more common abnormalities. The ability to conceive remains a debatable issue as well There is insufficient data on surgical correction (metroplasty); therefore, it is not usually indicated; however, excision of the vaginal septum may be required if the women is symptomatic. Didelphys uterus is not an indication for caesarean delivery unless the vaginal septum is thick and inelastic resulting in an increased risk for vaginal dystocia. Cervical incompetence has not been shown to occur in conjunction with the didelphys uterus. Lastly, when a didelphys uterus is diagnosed, renal anomalies should also be investigated to rule out Herlyn Werner-Wunderlich (HWW) syndrome.

REFERENCES

1. Heinonen P. K. Uterus didelphys: a report of 26 cases. European Journal of Obstetrics & Gynecology and Reproductive Biology. 1984;17(5):345– 350.
2. Heinonen P. K. Clinical implications of the didelphic uterus: long-term follow-up of 49 cases. European Journal of Obstetrics & Gynecology and Reproductive Biology. 2000;91(2):183–190. doi: 10.1016/S0301-2115(99)00259-6.
3. Raga F., Bauset C., Remohi J., Bonilla-Musoles F., Simón C., Pellicer A. Reproductive impact of congenital Müllerian anomalies. Human Reproduction. 1997;12(10):2277–2281. doi: 10.1093/humrep/12.10.2277.
4. Nahum GG. Uterine anomalies, induction of labor, and uterine rupture. Obstet Gynecol. Nov 2005;106(5):1150-52.
5. Ravasia DJ, Brain PH, Pollard JK. Incidence of uterine rupture among women with mullerian duct anomalies who attempt vaginal birth after caesarean delivery. Am J Obstet Gynecol Oct 1999;181(4):877-81.