

Case Report

Lower Segment Caesarean Section for Footling Breech in Unicornuate Uterus without Rudimentary Horn

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ABSTRACT:

Unicornuate uterus is a rare condition. It is commonly associated with subfertility and poor pregnancy outcomes with a live birth rate of only 29.2%. A case with successful pregnancy outcome is, therefore rare and this case highlights one such exception which was managed well in a referral center.

Keywords: Unicornuate uterus without rudimentary horn, footling breech, lower segment caesarean section

Received: 12 December, 2020

Accepted: 16 December, 2020

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This article may be cited as: Vohra P, Jain K. Lower Segment Caesarean Section for Footling Breech in Unicornuate Uterus without Rudimentary Horn. Int J Res Health Allied Sci 2021; 7(2):49-51.

CASE REPORT

A 21 year old primigravida presented to us as a referred patient with chief complaints of pain abdomen since 12 hours and leakage per vaginum since 6 hours. Patient was unaware of her Last Menstrual Period (LMP) and was not regularly booked and supervised in any health facility. She had visited a Community Health Centre once and got basic investigations as well as an ultrasound done in which she was told to have breech presentation. Her Period of Gestation (POG) according to the Ultrasonogram (USG) of 30.5 weeks was 35.2 weeks. Her past medical and family history was not significant. She was a vegetarian by diet and a non-smoker and non- alcoholic. She had no history of bleeding per vaginum.

EXAMINATION:

On general examination, her Blood Pressure was 110/80 mm Hg and heart rate was 90 bpm. She was afebrile and her SpO₂ was 99% on room air. On per abdomen examination, uterus was 32 weeks size, the presentation was breech and regular contractions were present. Fetal heart was regular on auscultation with a stethoscope and

rate was 140 bpm. A per vaginum examination was done and os was 3 to 3.5cm dilated, cervix was soft, central, 2cm in length. Presenting part was foot which had prolapsed. Liquor was clear. On the basis of these findings, a decision for emergency Lower Segment Caesarean Section (LSCS) was taken.

INVESTIGATIONS:

Blood group- B+
HIV- NR
HBsAg- NR
VDRL- NR
Hb- 10.9
TLC -12600
Platelets- 2.23 L
LFT- WNL
RFT- WNL

INTRA-OPERATIVELY:

Lower Uterine Segment (LUS) was not well formed. The presentation was same as confirmed on examination and a live born female child of 2.14Kg was extracted as breech. The baby cried immediately at

birth, umbilical cord was triply clamped and cut. The baby was handed over to the pediatrician. The patient was found to have unicornuate uterus without rudimentary horn (figure 1, figure 2). A clear cyst of size 3x3cm was found arising from the left ovary. There was no septum in the uterine cavity. Uterus was closed in 2 layers after securing bilateral uterine angles. Abdomen was closed in layers. Approximate blood loss during surgery was roughly 300ml. Post-operative period was uneventful. Foley's catheter was removed on Day 1 post-op. Patient was discharged after suture removal on Day 6.



Figure 1: Intra-operative image of a 21 year old female showing unicornuate uterus without rudimentary horn.

DISCUSSION

Normally, both Müllerian Ducts fuse to form uterus, fallopian tubes, cervix and proximal two-thirds of the vagina. Congenital uterine anomalies are a result of an abnormal formation, fusion or reabsorption of the Müllerian ducts, therefore leading to an abnormal or failed development of one of the ducts. The incidence can vary from 1 to 10% in general population, 2 to 8% in women with infertility and 5 to 30% in women with a history of miscarriages¹. The exact prevalence in population is difficult to ascertain due to no universal classification and best diagnostic techniques being invasive.



Figure 2: Intra-operative image of a 21 year old female showing unicornuate uterus without rudimentary horn.

Many classifications of uterine anomalies include American Fertility Society (AFS) classification, Modified AFS classification by Rock and Adam and Buttram and Gibbons Classification. According to the AFS classification:

1. Segmental müllerian hypoplasia or agenesis
 - 1.1. Vaginal
 - 1.2. Cervical
 - 1.3. Uterine fundus
 - 1.4. Tubal
 - 1.5. Combined anomalies
2. Unicornuate uterus
 - 2.1. Communicating rudimentary horn
 - 2.2. Noncommunicating horn
 - 2.3. No endometrial cavity
 - 2.4. No rudimentary horn
3. Uterine didelphys
4. Bicornuate uterus
 - 4.1. Complete- division upto internal os
 - 4.2. Partial
5. Septate uterus
 - 5.1. Complete- septum upto internal os
 - 5.2. Partial
6. Arcuate uterus
7. Diethylstilbestrol related

Uterine anomalies are associated with increased risk of malpresentations, prelabour premature rupture of membranes (PPROM), preterm birth, caesarean section, placenta previa, placental abruption and Fetal Growth Restriction (FGR)². Unicornuate uterus is present in 0.1% of general population. A live birth rate of only 29.2%, a 44% prematurity rate and a 4% rate of ectopic

pregnancy are reported³. 24.3% rate of first trimester abortion, 9.7% second trimester abortion and 10.5% Intrauterine Fetal Demise (IUFD) have been reported⁴. Increased rates of first trimester abortions, FGR, IUFD and still births may be explained by abnormal uterine blood flow owing to absent Uterine or Ovarian artery of one side. On the other hand, second trimester abortions and preterm deliveries are thought to be due to cervical incompetence and decreased muscle mass in the uterus. Our patient had unicornuate uterus without rudimentary horn, therefore coming in the type 2 of this classification which is associated with unilateral hypoplasia or agenesis⁵. A 50-90% risk of uterine rupture is there with approximately 80% occurring by the end of second trimester⁶. Our patient presented with preterm labour, premature rupture of membranes, malpresentation and FGR.

CONCLUSION:

Unicornuate uterus without rudimentary horn is a rare condition. It is associated with many complications that contribute to adverse fetal outcomes. However, with timely intervention and careful approach, live birth with minimum morbidity to the mother and child is possible.

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