

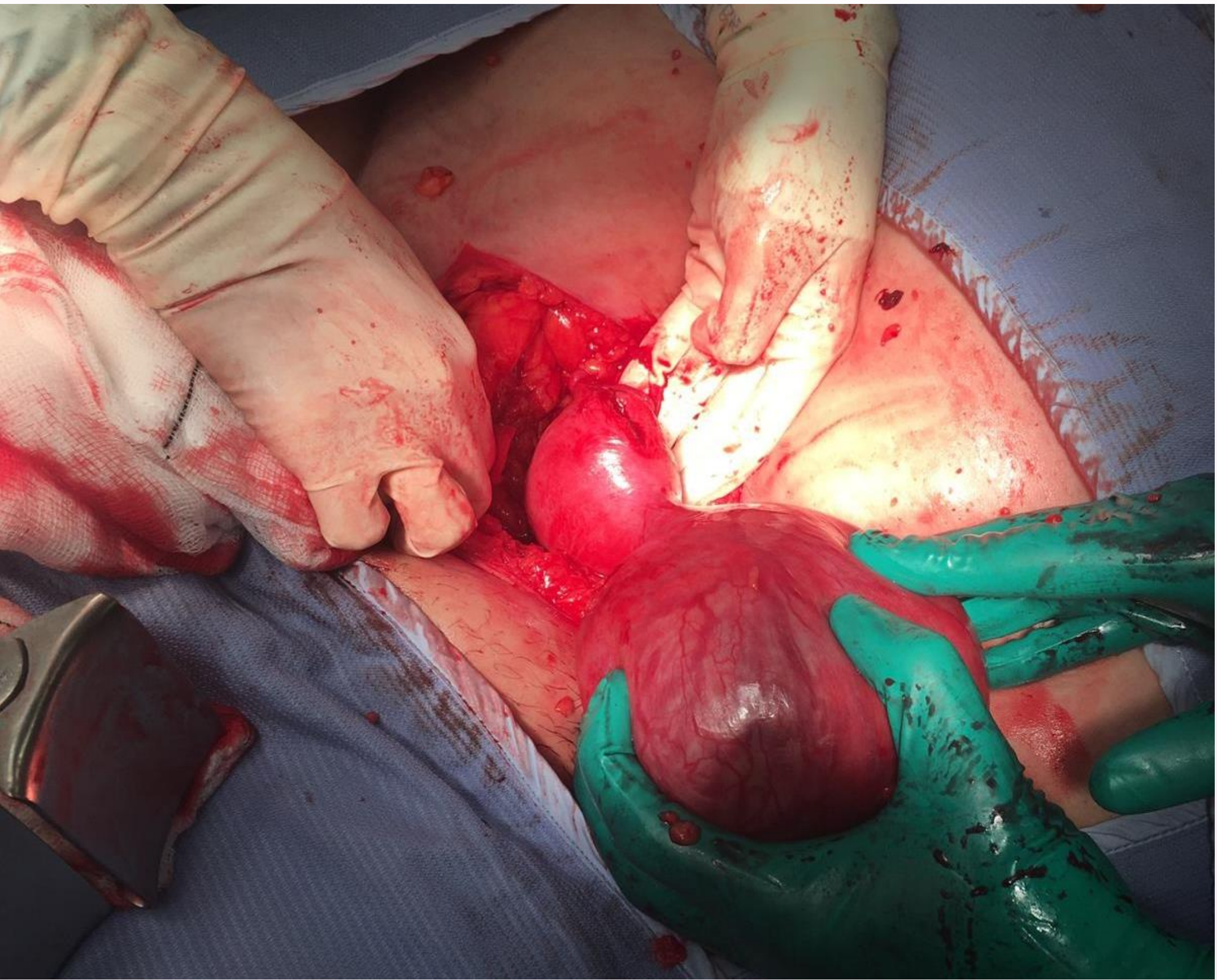
Complex IUFD management due to unsuspected interstitial pregnancy and uterine variant

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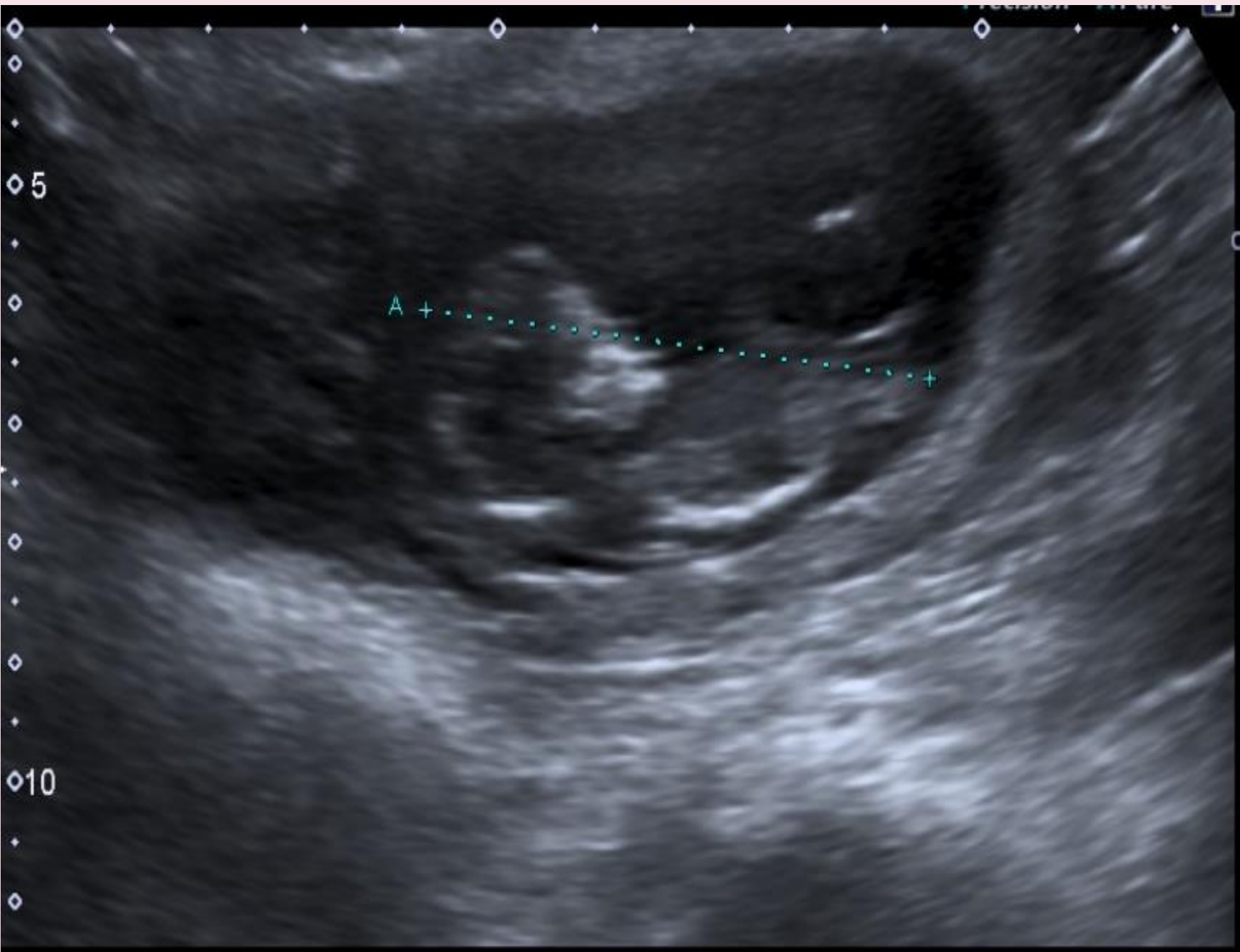
Uterine variants can complicate the management of seemingly routine conditions

In this case a unicornuate uterus with rudimentary horn led to unsuccessful medical treatment and complex surgical management of intrauterine fetal death

- P₁ CS for breech presentation
- Routine dating and nuchal USS – Not demonstration of uterine anomaly
- IUFD diagnosed at 20 weeks
- Mifepristone and large doses of misoprostol failed to initiate labour and delivery
- Referred to quaternary center for surgical management
- After unsuccessful medical management of late miscarriage proceeded to USS guided dilation & evacuation
- Perforation of uterine fundus with curette and subsequent small bowel injury – converted to laparotomy
- Laparotomy revealed a left interstitial pregnancy in vestigial horn with a fundal perforation of the right-sided hemiuterus
- Small bowel damage repaired by resections with functional end-to-end anastomosis



Macroscopic examination showing left interstitial pregnancy with fundal perforation of the right sided hemiuterus



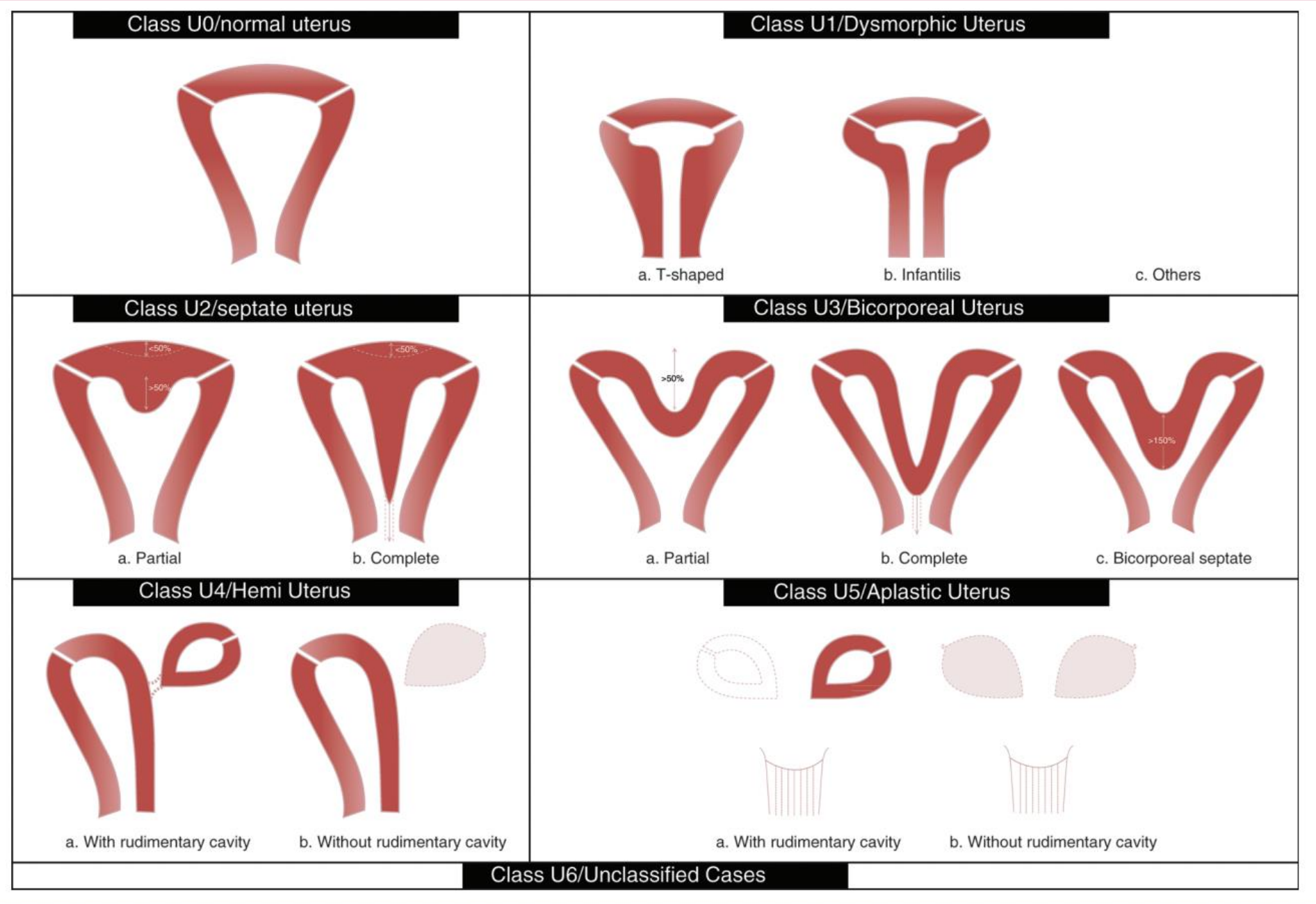
Routine dating scan and nuchal USS – myometrial thickness consistent with intrauterine location

Discussion

- The uterine variant in this case has only been assessed during pregnancy but seems most likely to be unicornuate uterus with left sided rudimentary horn (rAFS Type II a or b; CONUTA Class U4a)
- The first pregnancy proceeded uneventfully and must have gestated in the right-sided dominant hemiuterus. The left sided vestigial horn was noted at Caesarean but the patient was lost to follow-up.
- The second pregnancy was unmanageable medically and transcervically due to its vestigial horn location; this was not apparent until serious complication had occurred
- Repeated ultrasound assessments of the pregnancy did not suggest any uterine abnormalities or abnormal pregnancy location, exemplifying the diagnostic challenges of uterine variants

Conclusion

- This case exemplifies the challenges to diagnosis and management that uterine variants can present. It also highlights the need for detailed appreciation of clinical findings and may help clinicians lower their index of suspicion for anatomical variants



Uterine anomaly		Cervical/vaginal anomaly	
Main class	Sub-class	Co-existent class	
U0	Normal uterus	C0	Normal cervix
U1	Dysmorphic uterus	C1	Septate cervix
	a. T-shaped b. Infantilis c. Others	C2	Double 'normal' cervix
U2	Septate uterus	C3	Unilateral cervical aplasia
	a. Partial b. Complete	C4	Cervical aplasia
U3	Bicorporeal uterus	V0	Normal vagina
	a. Partial b. Complete c. Bicorporeal septate	V1	Longitudinal non-obstructing vaginal septum
U4	Hemi-uterus	V2	Longitudinal obstructing vaginal septum
	a. With rudimentary cavity (communicating or not horn) b. Without rudimentary cavity (horn without cavity/no horn)	V3	Transverse vaginal septum and/or imperforate hymen
U5	Aplastic	V4	Vaginal aplasia
	a. With rudimentary cavity (bi- or unilateral horn) b. Without rudimentary cavity (bi- or unilateral uterine remnants/ aplasia)		
U6	Unclassified malformations		
U		C	V

ESHRE/ESGE classification of uterine anomalies: schematic representation