

Fetal anomaly due to uterine anomaly: a case report

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Background

Congenital uterine anomalies are known to be associated with adverse pregnancy outcomes and the incidence varies in different population subgroups. Individuals with infertility or recurrent pregnancy losses being the groups with the greatest incidence of congenital uterine anomaly.

Despite an insignificant difference in conception rates, congenital uterine anomalies do cause a significant increase in the rates of reproductive loss, premature delivery, and adverse obstetric complications. Due to lack of any symptoms, congenital uterine anomalies are quite often detected during pregnancy or delivery.



Case presentation:

A 32-year-old primigravida with a diagnosis of cervical incompetence, based on ultrasounds in her second trimester, was transferred to our hospital at 21+ weeks gestation from a neighboring country. After a speculum and digital examination, it was revealed that the cervical os was closed with no signs of cervical incompetence. She underwent a fetal anomaly scan, which revealed an intrauterine septum with the fetal head stuck underneath the edge of the septum. The fetal scalp had also developed a caput that gave the impression of bulging of membranes on ultrasound; further scanning also reported severe ventriculomegaly. Following detailed counselling regarding the baby's prognosis, the parents chose to terminate the pregnancy. A male still born fetus was delivered with signs of strangulation, but the placenta was unfortunately retained. She was taken to the operating room for EUA, during which the placenta was found to be morbidly adherent and the septum being extremely obstructive for any digital access. Further mechanical manipulation was avoided. An MRI was performed followed by a laparotomy in which the placenta was removed through a hysterotomy incision at the level of placental insertion. After contraception for 6 months the patient underwent hysteroscopic septum resection. Three months after hysteroscopic resection, she conceived again and was delivered at 37 weeks by cesarean section. She also developed a pulmonary embolus later and was treated accordingly. She was later on discharged home with a healthy baby.

Conclusion:

Uterine anomalies are often asymptomatic but can present with unusual clinical presentations. Such anomalies should be treated appropriately to improve reproductive outcomes.

Keywords: Congenital uterine anomalies, Septate uterus, Ventriculomegaly, Hysteroscopic Septum Resection.