

Uterine Didelphys and Endometrial Adenocarcinoma: A Case Report

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Introduction

Congenital uterine malformations occur in the general population at a rate of 4-7%¹. Uterine didelphys is an uncommon class III Müllerian duct anomaly and is characterized by the presence of two uteruses and cervixes. Endometrial cancer in association with uterine didelphys is exceedingly rare, with few reported cases².

Case Report and Management

A 56-year-old lady presented with postmenopausal bleeding on a background of uterine didelphys. Other relevant medical conditions included a body mass index (BMI) of 45, type 2 diabetes mellitus and hypertension. At hysteroscopy, it was not possible to gain entry and obtain biopsies as both cervical ostia were significantly stenosed.

To further evaluate her endometrial cavity, an MRI was performed, revealing an endometrial thickness of 17mm in the right cavity, and 10mm in the left. The patient was offered the option of surgery or interval repeat imaging for surveillance, given her significant medical comorbidities and potential surgical risk.

The patient opted for repeat imaging, however failed to attend any follow up appointments, having moved country. In her new place of residence, she had a significant haemorrhage and underwent a laparoscopic hysterectomy and bilateral salpingo-oophrectomy. Histology confirmed stage 1a endometrial adenocarcinoma.

The patient has been followed up at 6 monthly intervals, and remains free of recurrence.

Discussion

Endometrial cancer is one of the most common neoplasms of the female reproductive tract. However, endometrial cancer with uterine didelphys is very rare. Only 13 cases have been reported in the last 25 years³.

This case presented numerous challenges, including difficulty in obtaining an endometrial biopsy, in a patient with significant medical comorbidities.

Given the patient's reluctance to undergo surgical intervention, medical therapy with progestins may have been offered if biopsy and MRI correlated with stage 1a disease. Patients opting for such a strategy should be aware of the risk of treatment failure and the need for close surveillance, which would have been difficult in this case given the challenges in obtaining a biopsy in the first instance⁴.

Conclusion

Endometrial adenocarcinoma in the setting of uterine didelphys is rare. Challenges in this case included difficulty in obtaining endometrial biopsies on a background of significant medical comorbidities and poor compliance with follow up. Ultimately, in the setting of a significant haemorrhage, surgical intervention was required.



References

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