

A CASE REPORT OF A TUBAL ECTOPIC PREGNANCY IN A HEMI-UTERUS WITH A RUDIMENTARY HORN.

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Introduction

A hemi-uterus with a rudimentary horn is a rare Müllerian anomaly, which occurs from incomplete atresia of one of the Mullerian ducts during development. The prevalence of this anomaly is approximately 1 in 100,000.¹ In 75% of the cases, there is no communication between the endometrial cavities.^{2,3} If the two cavities are communicated, a pregnancy in the rudimentary horn may lead to ectopic pregnancy, uterine rupture and haemoperitoneum with a high risk of maternal mortality.

Case

A 36-year-old lady in her second pregnancy at 10 weeks of amenorrhoea was admitted with a left side ectopic pregnancy who has had secondary subfertility following T1 miscarriage for 5 years. She attained menarche at 12 years; since then, she has had regular cycles with normal flow; however, she complained of progressive dysmenorrhoea since menarche and right sided abdominal pain, for which she had been investigated several times in the past including a laparoscopy. She underwent an EM/laparoscopy and found to have a hemi-uterus with a right rudimentary horn. The left tube and ovary were connected to the hemi-uterus, with a ruptured left tubal ectopic and 150ml of haemo-peritoneum. The right tube and ovary were attached to the rudimentary horn, which was connected to the hemi-uterus with a streak of tissue. Left side salpingectomy was done

Discussion

Diagnosing hemi-uterus with rudimentary horn is challenging and often delayed due to its low prevalence, lack of clinical suspicion and limitations of conventional ultrasonography. Diagnostic modalities include HSG, 2D USS, 3D-USS, MRI, and combined laparoscopy with hysteroscopy. 3D-USS has a higher accuracy rate than 2D-USS, while MRI offers a sensitive, non-invasive approach to assessing internal and external uterine contours. Many have suggested that hysteroscopy combined with laparoscopy is the gold standard as this offers the advantage of concurrent treatment, such as resection of the rudimentary horn³.

In this case the diagnosis was made during emergency laparoscopy for ruptured tubal ectopic and further evaluation has been planned with MRI to assess communication between the hemi-uterus and rudimentary horn, the presence of functional endometrium and associated renal anomalies. Hysteroscopy may be needed in case of further diagnostic doubt. Once diagnosed, surgical excision of the non-communicating functional rudimentary horn and referring for IVF treatment will be recommended to treat subfertility and avoid further potential complications.

Conclusion

The above case highlights the importance of having a high index of suspicion in cases of progressive dysmenorrhoea and abdominal pain after menarche. Different diagnosing modalities are essential for early diagnosis and to prevent gynaecological or obstetric complications.

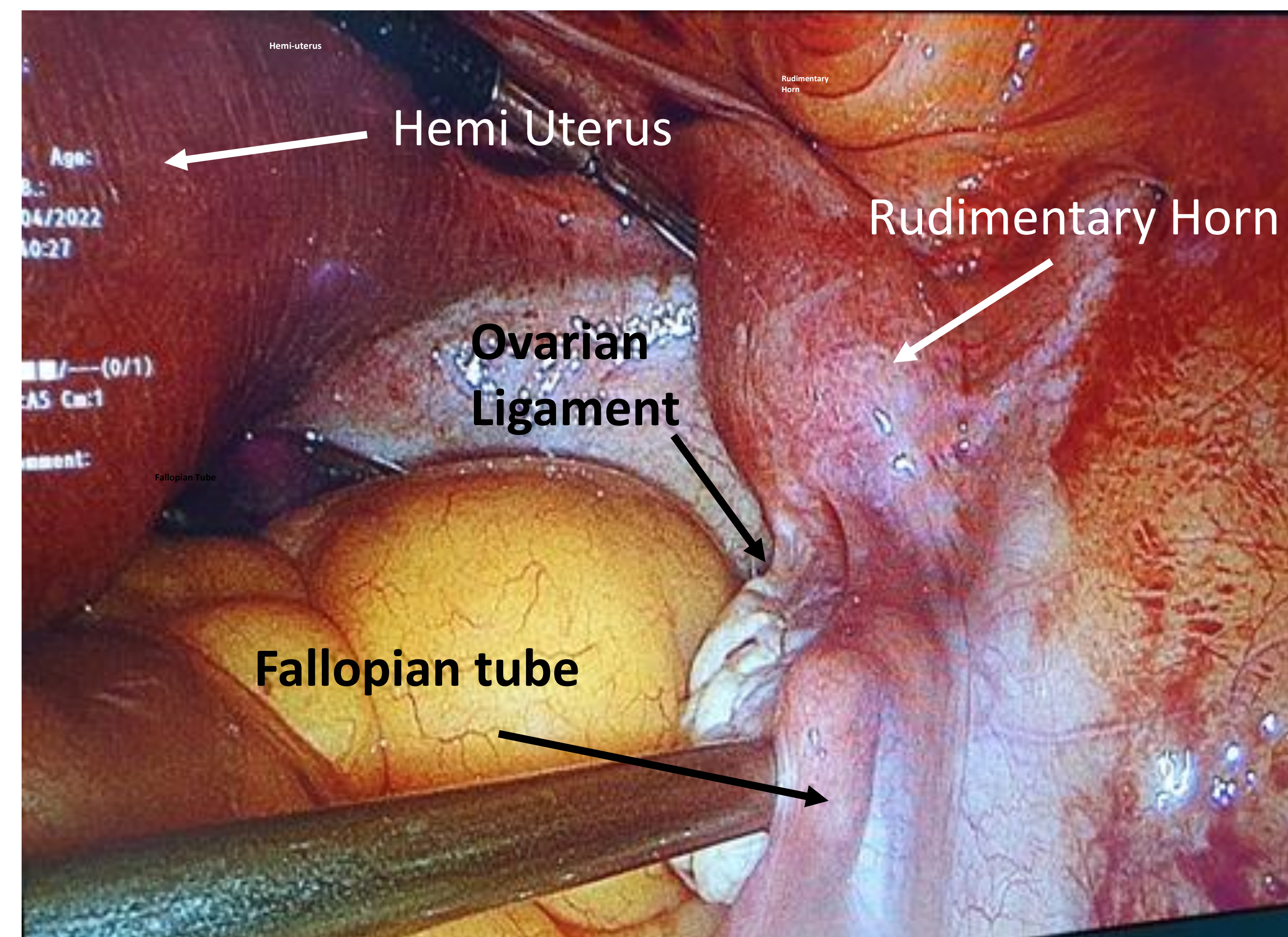


Figure 1 – Laparoscopic view of the anomaly

References

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