CASE REPORT

TERM PREGNANCY IN A UNICORNUATE UTERUS DIAGNOSED AT CAESAREAN DELIVERY FOR ECLAMPSIA

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INTRODUCTION

Unicornuate uterus is rarely seen in clinical practice. The incidence is about 1/4000.[1] The reproductive performance of women with unicornuate uterus is usually poor.[2] Women with unicornuate uterus are at risk of abortions, preterm delivery, abnormal presentation and intrauterine growth restriction but some may have no adverse pregnancy outcome.[1,3,4] Live birth rate of 49.9% has been reported with a caesarean delivery rate of 33.8%.[5] Unlike bicornuate and septate uteri, surgical correction is not necessary in women with unicornuate uterus except with a rudimentary horn.[6,7]

CASE REPORT

An 18-year-old primigravida was rushed into the labour ward with history of repeated convulsions at term. She booked for antenatal care at a peripheral hospital at 22wks of gestation with a booking blood pressure of 90/50mmHg.

She was one year into her marriage. None of her five sisters had pregnancy wastages or difficulty getting pregnant. Her mother, a traditional birth attendant (TBA) has had eight unsupervised pregnancies and deliveries. She attained menarche at 14years and had a regular cycle with normal flow.

On examination, she was found to be a young woman in post ictal sleep, who was afebrile to touch and neither pale nor icteric. There was an accessory nipple on the right breast. Her pulse rate was 96beats/minute and the blood pressure was 140/80mmHg.On abdominal examination, the gravid uterus was deviated to the right side with a symphysiofundal height of 34cm.The presentation was cephalic and the head was felt midway between the umbilicus and the pubic symphysis. There was no skeletal abnormality and the kidneys were not ballotable. The fetal heart rate was regular and no contractions were felt. Vaginal examination revealed narrowing of the vagina towards the vault with a urethral diverticum extending the whole length of the urethra. The cervix was 3cm long and tightly closed. The pelvis was clinically adjudged borderline

Investigations requested (FBC, E/U/C and LFT), were essentially within normal limits except for Proteinuria of 3+. At emergency caesarean delivery, the uterus was wholly on the right side and the lower segment thinned out. The head was high and liquor was clear but scanty. A female baby with Apgar scores of 4 and 8 at one and five minutes respectively who weighed 2.5kg was delivered. The uterus was observed to be oblong in shape with apparently normal myometrium but with undue thinning of the lower segment. There was an ovary, tube, and round ligament on the right side. These were not seen on the left side. There was no malposition of the kidneys. The patient was discharged home on the seventh postoperative day, and though asked to come for follow up, she failed to return after the puerperium. The follow up would have afforded us opportunity for further investigations to rule out urinary tract abnormalities and counsel her on future obstetric adventures.

DISCUSSION

The three most plausible theories that explain the poor reproductive outcomes in unicornuate uterus are diminished muscle mass, abnormal uterine blood flow and cervical incompetence[5].

Women with unicornuate uterus may be asymptomatic and only diagnosed at caesarean delivery as in the case presented.[1]Many that have had successful vaginal deliveries with Mullerian abnormalities will go undiagnosed and this will affect the true incidence of congenital uterine malformations. Many studies report that congenital uterine anomalies are associated more with problems of maintaining pregnancy rather than infertility.[3,4,8]

Our patient did not manifest with either as she presented with a term pregnancy after about one year of marriage. Although the diagnosis of uterine anomalies can be confirmed by radiological tests like transvaginal ultrasonography, hysterosalpingogram, magnetic resonance

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imaging, hysteroscopy, sonohysterography and more recently 3-D ultrasonography; [3,9] the diagnosis in asymptomatic women is usually incidental as in this case. In a review of literature on pregnancy outcome in unicornuate uterus, Reichman et al[1] found that 49.9% of patients delivered a live baby, 2.7% had ectopic pregnancy, 34% had miscarriage, 20% had preterm delivery, and the rate of intrauterine demise was 10%. Many other reports have associated poor pregnancy outcome in women with uterine anomalies. [8,10,11] Our patient had a caesarean delivery for antepartum eclampsia at term suggesting that the pregnancy might have continued if eclampsia had not set in. The long and tightly closed cervix is a pointer that the cervix is unlikely to yield anytime soon. The urethral diverticulum and the low level of the uterovesical peritoneal fold suggest associated urinary tract malformations. It is a well-known fact that the urinary tract develops closely with the reproductive system and therefore malformation in one could lead to disturbance in the other. It was against this backdrop that the patient was requested to do an intravenous urogram after the puerperium but like many patients in this part of the world, she was lost to follow up.

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