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Successful Out Come Of Twin Pregnancy In Bicornuate Uterus In A Primigravide: A Case Report

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Abstract
Bicornuate uterus is one of the main causes of spontaneous miscarriage, malpresentation, preterm deliveries and occasionally difficulty in spontaneous conception. Recurrent pregnancy loss rate has been reported to be 15% to 27%. Bicornuate uterus is one of the types of mullerian duct anomalies like uterine didelphys, septate uterus, arcuate uterus, unicornuate uterus with a prevalence of about 7-8% in the general population. In any case of recurrent pregnancy loss, malpresentation, IUGR and preterm deliveries the above uterine anomalies should be considered as differentials. Here we present a case of bicornuate uterus were twin pregnancy was carried till 35wk 5d and had a successful outcome following caesarean section.

Keywords*: Mullerian anomaly, bicornuate uterus, Twin Pregnancy, Caesarean section.*

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I. INTRODUCTION

Congenital uterine deformities arising from the non fusion of the mullerian duct in early embryonic life.These anomalies are associated with increased risks of miscarriage, preterm deliveries and other 3rd trimester complication like malpresentation.[1]

Reproductive capabilities of women can also be affected by bicornuate uterus. In the general population, uterine malformations are estimated as 3% to 5%.[2]Other literature reported 7% to 8%. Congenital malformation of the uterus is one of the leading causes of recurrent 2nd trimester miscarriage and has been reported to range from 15% to 27%.[3]

Precise investigative tools are required to diagnose Bicornuate uterus and these include; pelvic examination, Hysterosalpingogram, transvaginal ultrasound and magnetic resonance imaging. For a woman with recurrent pregnancy losses, surgical intervention may be the only option available i.e. laparoscopic metroplasty,which result in a good unified uterine cavity with minimal intrauterine adhesion formation.[4] Therefore, a case of successful pregnancy outcome in a patient with Bicornuate uterus is discussed in this report. The outcome can be improved through early diagnosis and close surveillance with proper treatment.

II. CASE REPORT

A 27Yr old P_0 +0 who was first seen at the gynae clinic in April 2022 with 10Year H× of infertility, she is in her 2nd order of marriage for 5years. TVS shows intact endometrial plate, cervical region showed cavity fluid however the mucosa and echo pattern were preserved, the ovaries has multilocular cyst. HSG was requested but there was difficulty in catheterization and she was booked for EUA.

Gentle pelvic examination revealed a thin low transverse vaginal septum which was excised out and about 5mls of copious discharge evacuated and two patent cervical os seen. We later proceed with exploration and finding of bicornuate uterus and polycystic ovaries were noted. She was later discharged to be seen in gynae clinic.

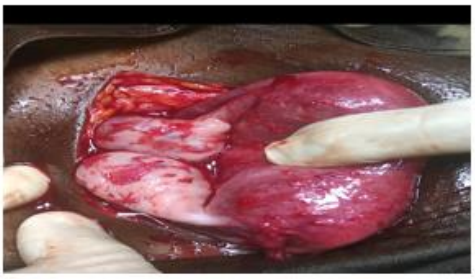
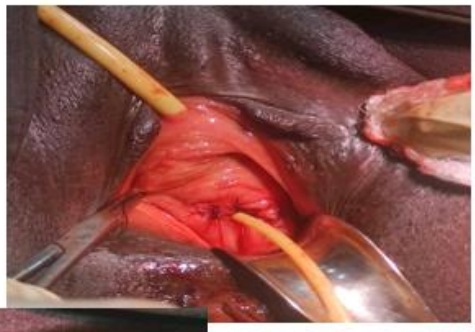


Figure 1, 2 & 3: Showing bicornuate uterus, Polycystic ovaries and 2 visible cervical os.

She had HSG 3 months later which confirmed bicornuate uterus. She had a cycle of ovulation induction with letrozole 2.5mg and she presented at the gynae clinic 6weeks later with H_X of menorrhea. Serum PT was positive and ultrasound confirmed early viable set of twin. She was counseled and reassured and commenced on haematinics and booked for ANC in early 2nd trimester. She had a repeat USS @ 28 WKS, there is a uterine band of tissue, arising from the posterior cervix splitting the cavity into two. Each of the endometrial cavities contains a live fetus and a placenta.


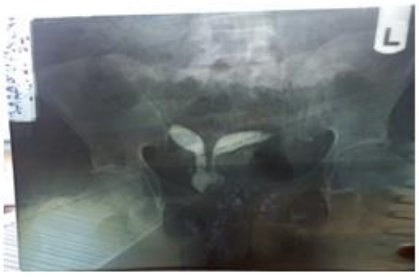

Figure 4: HSG showing two separate uterine horns.

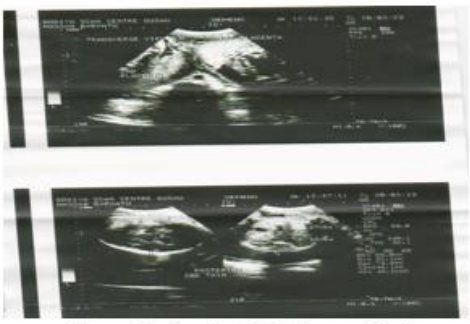
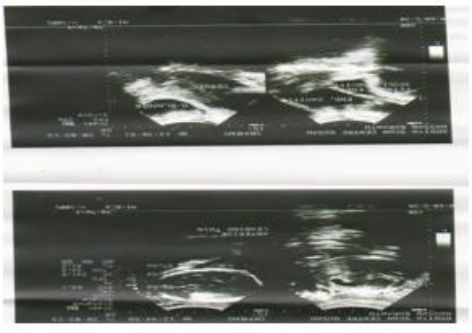

Figure 5: showing USS done at 28wks gestation.

Pregnancy remained uneventful until 35weeks+ when she presented at the ANC with complain of drainage of liquor of 4 day's duration without fever. Basic investigations done she was given 2 doses of I.M Dexamethasone and parenteral antibiotics. She subsequently had emergency CS and was delivered of up live female neonate weighing 1.8kg with Apgar score at 1 and 5 minute of 7 & 8 respectively, male neonate weighing 1.9kg. The babies were later admitted to SCBU and were discharged to their mother after 24hours to commence breast feeding which provide immunity and create bonding.[5]

III. DISCUSSION

Congenital uterine anomalies are sometime a symptomatic and relatively common. Women with uterine anomalies have lower pregnancy rate and fair reproductive outcome compared with women with normal uterus. Uterine abnormalities occur as a result of Mullerian or paramesonephric ducts anomalies at the time of fusion or development. One of these anomalies is Bicornuate uterus, cause by abnormal incomplete lateral fusion of ducts having a fundal indentation of more than 1cm and angle between 2 endometrial cavities is 105 degrees.[6] This condition can be diagnosed before or during pregnancy. Uterine anomalies are associated with increase risk of 2nd trimester miscarriage, PROM, IUGR and abnormal presentation with increase risk for caesarean section. Early ultrasound is a contributing method for evaluation of the effects of abnormal uterus on pregnancy,[7]however in this case ultrasound failed to detect the abnormal uterus but hysterosalpingogram diagnosed the uterine anomaly. What is interesting about the diagnosis in this patient was that during the exploration the uterus appeared Bicornuate and on HSG it appeared didelphys. Unification of the uterus by metroplasty may improve the obstetric out come to 60%-85%.[6] Following the evaluation and commencement of ovulation induction with letrozole a month later she conceived a set of twin and at 35weeks + she had emergency CS on account of preterm PROM, prolonged history of infertility and twin gestation in aprimigravidae.She was delivered up a healthy female neonate weighing 1.8kg and a male neonate weighing 1.9kg. She was stable with her babies and was later discharged home after a week to see post natal in 2weeks.Increase awareness among women and general population about the possible outcome of this condition by the obstetrician is of enormous importance. It's equally important to establish the potential diagnosis to ensure proper care and prevent complications.

IV. Conclusion

Pregnancy in a bicornuate uterus requires early evaluation and diagnosis of the anomaly, meticulous care in pregnancy and delivery to prevent associated adverse outcome. Obstetrician should have high index of suspicion of uterine anomaly to make early diagnosis and prevent complications.

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