

Uterus Didelphys with Endocervical Polyp - A Rare Case Report

Dr. Eda. Indira, Dr. V. Indira Kumari, Dr. G.Ratna,

[Dept of OBG, Siddartha Medical College, Dr.Ntruhs, Vijayawada, AndhraPradesh, India]

Abstract: Uterus Didelphys, a Congenital anomaly of uterus with a soft vertical vaginal septum reported to the Gynec OPD with complaint of irregular post menopausal bleeding and offensive vaginal discharge. On examination, found to have two uterus and two cervixes with a soft vertical vaginal septum and endocervical polyp of 5x3 cm size, was found in one of the cervix which was pedunculated and bleeding on touch. Surprisingly she had 4 children, all of them were full term normal deliveries conducted by local dai at home. She was subjected to ultra sound abdomen which confirmed Uterus Didelphys with endocervical polyp. She does not have any renal abnormalities. She was put on antibiotics to control the infection, Polypectomy was done followed by TAH + BSO after 3weeks. Management of the case is discussed.

Keywords: Uterus Didelphys, Mullarian duct, Endo cervical polyp, Vertical vaginal septum, Chronic non specific cervicitis, Polypectomy, TAH + BSO.

I. Introduction

Uterus didelphys is a congenital uterine anomaly, that occur due to mullerian duct abnormalities. These anomalies are important to recognize as some of these may have a grave implication on future obstetric outcome. Embryologically the uterus is developed from the fusion of mullarian ducts from below upwards, their adjacent walls breaking down to form a single cavity. Fusion begins at 7- 8 weeks and completes by 12 th week. Cervix is developed from the fused lower vertical parts of the two paramesonephric ducts. Vagina is developed mainly from the mullarian ducts and partly from the urogenital sinus. Vaginal introitus is developed from the ectoderm of the genital folds after rupture of the bilaminar urogenital membrane.

Uterus didelphys results from the complete lack of fusion of mullerian ducts with double uterus, double cervix and double vagina. Vertical vaginal septum results from failure of fusion of distal parts of mullarian ducts and it is associated with septate uterus or Uterus didelphys. The septum may be complete or partial. Incidence of mullarian duct anomalies is 0.001 – 10%. The incidence of uterus didelphys is 10%.

II. Case Report

A 60 years old post menopausal woman came with complaint of irregular uterine bleeding and offensive vaginal discharge with a swelling in the vagina, lower abdominal pain, since one month. She was asymptomatic until that time. Previous menstrual history of 3/ 30 days, regular, normal flow, changed 2 to 3 pads per day, No dysmenorrhoea and no difficulty in coitus previously, attained menopause 20 years back. Her husband died 20 years back and having 4 children, Last child birth was 25 years. Obstetric history - All home deliveries done by local untrained dai. She was not tubectomised. Per abdominal examination: abdomen was soft and no scars, on per speculum examination there was a soft vaginal septum and two cervixes were visualised, a reddish polyp was seen which is pedunculated, protruding through one cervical os measuring 5x3 cms and bleeding on touch. Foul smelling vaginal discharge present. One of the uterus was bulky, retroverted , with a pedunculated polyp arising from the endocervical canal and the other uterus was atrophic and retroverted, , both the fornices were free. Patient was subjected to Ultrasound examination, which showed 2 uterus and cervixes with polyp. Endometrial thickness was 4mm.



Fig 1. Ultra sound image showing two uterine cavities and cervixes.

Routine blood and serological tests including Thyroid test, ECG, ECHO, Chest X ray were normal. Papsmear and cervical biopsies of both the cervixes showed features of chronic non specific cervicitis.

III. Management

Patient was admitted and kept on antibiotics, to control the infection. Polypectomy was done along with D&C under short general anesthesia. No uterine scrapings obtained from both the uterine cavities. HPE of polyp confirmed adenomatous endocervical polyp. Total Abdominal Hystrectomy with Bilateral Salpingo Oophorectomy (TAH + BSO) was done under spinal anesthesia after 3 weeks. Uterus didelphys with two uterus and cervixes were identified. There was a well developed vesicorectal fold in between two uterus. Right ovary was normal and left ovary rudimentary. Both Fallopian tubes were normal.

Cut section of uterus showed no abnormality in the cervix, endometrium, and in the myometium, large intramural fibroid present measuring 3.5x 2.5x 1 cms in one uterus, other uterus with cervix had no endometrial or myometrial and cervical abnormality. Post operative condition was uneventful, and patient was discharged on 8th postoperative day.

HPE showed one uterus with cervix, cervix having chronic nonspecific cervicitis. No evidence of dysplasia or malignancy but a small fibriod with secondary degenerative changes. The other uterus with cervix, cervix having non specific chronic cervicitis. No evidence of dysplasia or malignancy. Myometrium- foreign body giant cell reaction.



Fig .2 Fig.3



Fig.4

Fig.5

Fig 2. Picture showing endocervical polyp.

Fig 3. Per operative picture showing 2 uterus and 2 cervixes.

Fig 4. Picture showing excised 2 uterus, 2 cervixes and 2 fallopian tubes and 2 ovaries.

Fig 5. Picture showing soft vertical Vaginal septum.

IV. Discussion

The American fertility society classified the mullarian anomalies [1]. There may be Class I : Agenesis/ Hypoplasia, Class II : Unicornuate uterus, Class III : Uterus didelphys, Class IV : Bicornuate uterus, Class V : Septate uterus, Class VI : Arcuate uterus, Class VII : Diethyl stilbersterol related abnormality. Each of them may not be associated with vaginal septum [2]. The incidence of uterine anomalies is 3.2% in fertile population.

Although the uterine anomalies are rare, the woman with Uterus didelphys may be asymptomatic and unaware of having double uterus. They may present with hematocolpos, hematometra, dysmenorrhoea, and menorrhagia [3]. They may also have spontaneous abortions, obstructed labour, full term vaginal deliveries. The incidence of twins in women with uterus didelphys is much higher than normal, the ratio being 1:12 compared to 1:89 [4].

The vertical vaginal septum is complete and high partial [5]. Associated uterine malformations are frequent. The vaginal septum may cause difficulty in coitus, fertility problems, obstruction to the delivery of fetus, most of the times it is asymptomatic. One half of the vagina then usually dilated and the septum is pushed

to the side. The endocervical polyp in our case is a rare association. The polyp usually arises from the endocervix and rarely from the ectocervix. The clinical diagnosis of polyp will be made mainly during per speculum examination, Hysterosalpingography, Hysteroscopy.

Principle tools for diagnosis of uterine malformations and vaginal septum: Transvaginal Ultrasonography, Sonohysterography, Hysterosalpingography, MRI, Hysteroscopy, and more recently 3D Ultrasonography has been advocated as an excellent non invasive method to evaluate the uterine malformations [6]. MRI is an excellent tool for the diagnosis of uterine anomalies.

V. Conclusion

Most of the uterine abnormalities may not be diagnosed unless they are symptomatic. Majority were first diagnosed during pregnancy, as a result of pregnancy mishap, Uterine curettage, manual removal of placenta or during C- section and also during evaluation of infertility. Mere presence of any uterine malformation per se is not an indication for surgical intervention. Most of the cases are best left untreated. Uterus didelphys has high successful pregnancy out come with out metroplasty. Vaginal septa are generally symptomless and needs no treatment. It may cause dyspareunia or obstruct delivery of fetus, in such circumstances the septum needs to be excised. In our case the patient presented with uterus didelphys with infected endo cervical polyp with chronic non specific cervicitis. Considering her age and parity, we did TAH with BSO.

References

- [1]. American Fertility Society classification of mullerian anomalies (1988) Fertile Steril 49: 952.
- [2]. Peeti Nisture, Niranjana N Chavan, "Vaginal delivery in a case of longitudinal vaginal septum- an interesting case report" Bombay hospital journal, Vol 51,no2,2009.
- [3]. Keller.B.(1967): Bull.Fed.Soc.Gynec.Obstret.Franc., 19.371.
- [4]. Jarcho.J.(1946):Amer.J.surg.,71,109.
- [5]. B Haddad, C Louis, "Longitudinal vaginal septum a retrospective study of 202 cases" European journal of obstetrics and gynecology and reproductive biology vol 74 pp 197-199, 1997.
- [6]. Reproductive out comes in women with congenital uterine anomalies detected by 3D ultra sound screening Obs & Gyn 98 (6): 1099-103.