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Letter to Editor

Pregnancy Follow Up and Delivery of Didelphys Uterus: Case Report and Review of Literature

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DEAR EDITOR

Congenital uterine anomalies arise from abnormal embryological development of the paramesonephric ducts (or Mullerian ducts) [1]. Various anomalies result from arrested development of the uterovaginal primordium during embryonic period, by incomplete or failed development of parts of one or both paramesonephric duct, incomplete fusion of the paramesonephric ducts or incomplete canalization of the vaginal plate [2]. Prevalence of all types of female congenital reproductive tract malformations is estimated at 4%–7% and they are mostly benign [3].

Uterine didelphys is a rare type of anomaly with estimated prevalence of 0.3%, caused by complete failure of fusion of the inferior parts of the paramesonephric ducts resulting in separate uterine cavities with two cervices and a double or single vagina. Sometimes a longitudinal or transverse vaginal septum varying from thin and easily displaceable to thick and inelastic may also be associated with didelphys uterus [2,4]. Literature has further postulated a possible association of uterine didelphys with dyspareunia and dysmenorrhea during reproductive ages.

Uterine didelphys is associated with renal agenesis in approximately 25% of cases [5]. In the same study by Boehnke., the discovery of a materna-fetal matching phenotype raises the possibility of an inheritance pattern or genetic origin as opposed to previously hypothesized teratogenic or maternal influences on organogenesis. Rarely have reports of familial recurrence of didelphys uterus been made in the literature.

In pregnancy, like other Mullerian duct anomalies, uterine didelphys is associated with various obstetric complications like spontaneous abortions (with recurrent pregnancy losses), malpresentation, preterm delivery, preterm rupture of membrane, intrauterine growth restriction and the need for operative delivery [4].

30 years old female G2P1L0 at 40 weeks' gestation age was admitted as a self-referral from home with a one-day history of lower abdominal pain suspected to be labor pain in nature.

She had first booked Antenatal Clinic at approximately week 12 and she had made a total of 6 visits where she has had all supplements given according to the national Antenatal guidelines. There's no history of chronic diseases like Diabetes Mellitus and Hypertension and she has not reported any occurrence of the same in any of the siblings.

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She had reported an early neonatal death (death within 7 days of life) of the term baby in 2016 (Female 2.0Kg at 38 weeks gestational age) from previous pregnancy of unknown established cause because no autopsy was done and further details couldn't be retrieved regarding the first delivery. However, a suspicious sequela of congenital and/or intrauterine growth restriction complications might have been the cause.

She was diagnosed with uterine didelphys during an ultrasonographic evaluation at 36 weeks' gestation age on her Antenatal visit. She hasn't used any conventional family planning method like IUDs and she hasn't reported any difficulty in conception.

Figure 1: Obstetric Transabdominal Ultrasonography at 19 weeks revealing the other empty horn of the uterus

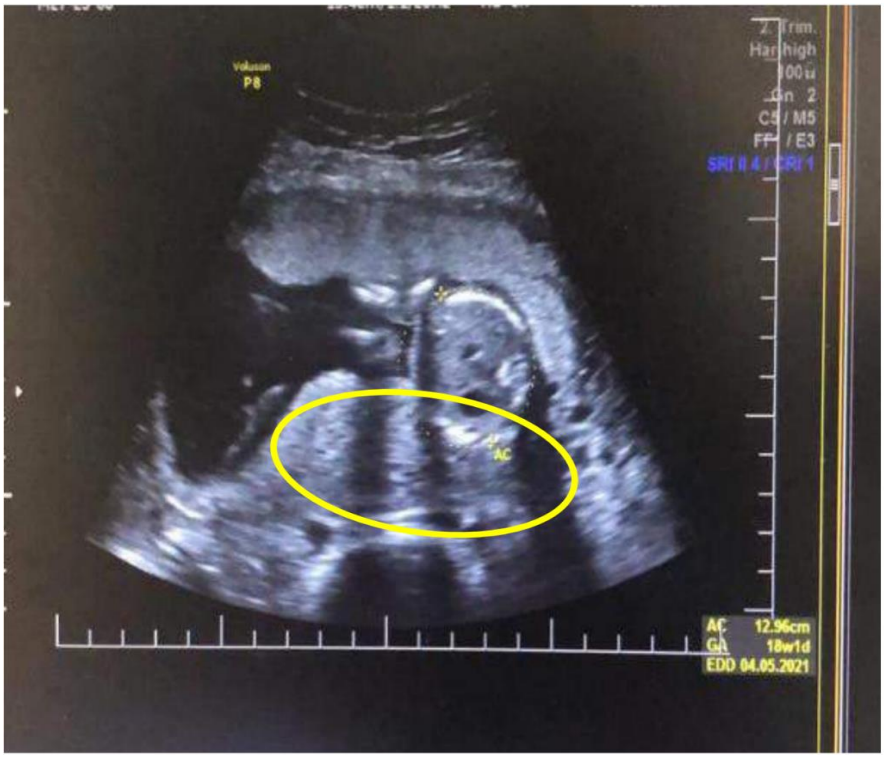

Figure 2: An Obstetrics Transabdominal Ultrasonography showing the relationship between the 2 horns of the uterus

Upon arrival at the Labor and Delivery Room; an initial assessment revealed a latency phase of labor (soft cervix posteriorly located; 2 cm dilatation and approximately 30% effacement) and she was then kept for observation and monitoring of the progress of labor was thoroughly done. She was otherwise afebrile, not dyspneic with stable vitals and regular fetal heart rates of 136 beats per minute.

Four hours later just before the next assessment she was found to be in the second stage of labor (precipitous labor) and had an uneventful delivery (without needing intrapartum assistance neither the use of oxytocic augmentation) of a Female Baby 2.1Kg and an APGAR Score of 7 and 9 during the 1st and 5th minutes respectively. After delivery, there were no observed complications like perineal tears or hemorrhage.

DISCUSSION

Uterine didelphys, like many uterine anomalies may be associated with one or more obstetric complications including recurrent early pregnancy loss [6], preterm birth [7], preterm prelabor rupture of membranes, malpresentation [8], low birth weight, intrauterine fetal demise and caesarean delivery [9]. With all these risks, the pregnancy progress especially the fetal monitoring is of paramount importance with consideration to regular consultations with Maternal Fetal Specialist and other routine testing [7]. Nevertheless, counselling on dating and mode of delivery should be initiated early in pregnancy [4].

It is our observation that some of the women with uterine anomalies might be either delivering without any notable complications or remain undiagnosed, some even after series of recurrent pregnancy loss [8]. Most of the Tanzanian women (especially from the rural areas) never get a proper radiological investigation from conception to delivery. Because this anomaly is asymptomatic and almost always accidentally detected which is likely the reason for the inaccuracy of frequency and hence lack of proper follow up. Although, the initial diagnosis is made by Ultrasound or hysterosalpingography, MRI offers the most accurate diagnosis [10]. While little is known on established true diagnosis antenatally, it remains of essential role to plan for a precise mode of delivery earlier on once detected [9].

In this presented clinical case, feto-pelvic incompatibility and non-reassuring fetal status were ruled out during labor thus proceeding to a normal delivery. Contrary to the expected inadequate uterine contractions, there was no augmentation with oxytocin that was done. A spontaneous onset of labor in a term pregnancy led to regular contractions that were uneventful with a healthy baby.

More than 80% of the pregnancies and childbirths in women with uterus didelphys end with a caesarean section but without immediate obstetric indication for it [8,11]. Vaginal septum may cause dystocia of the soft birth canal [8] and the arrest of progress of labor and these factors attributes to the high caesarean section rates observed in one study [3,12].

Another study even suggested that uterine didelphys should be considered in the intrapartum evaluation of women with suspected soft tissue dystocia [8]. In the case that we have just presented, no ligation of the vaginal septum was required as it did not interfere with normal delivery. Notwithstanding that labor dystocia in women with uterus didelphys may result from mechanical impediment, the question arises as to whether abnormal embryonic development of the reproductive organs is not a cause for the impaired function of the myometrium.

On the basis of our review of the literature, we think that CS in uterine didelphys is a sufficient, but not absolute indication for CS. We advocate, in support of the reports that showed a possible normal delivery in a didelphys uterus even after CS unless there is an obstetric indication.

Limitations

The author identified a limited access to more detailed information regarding the first delivery (small for gestation age that corresponds to the weight of 2kgs at term) and an established cause of the early neonatal death.

CONCLUSION

Despite literature suggesting poorer obstetric and neonatal outcomes in women with uterus didelphys who continue their pregnancies, we report the successful spontaneous delivery of a neonate in a woman with a uterus didelphys, the first such outcome in Tanzania.

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Guarantors

All the authors are the Guarantors of this paper since TJK, RIA managed the patient and collected all clinical information and wrote the manuscript while PW

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