VIA MEDICA

CLINICAL VIGNETTE

Ginekologia Polska
2020, vol. 91, no. 9, 569–570

ISSN 0017–0011

DOI: 10.5603/GP.2020.0089

A triplet's ectopic pregnancy in a non-communicating rudimentary horn and spontaneous rupture

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ABSTRACT

Our aim is to feature the management of ectopic pregnancy in a non-communicating rudimentary horn. It has a remarkable life-threatening potential, being rare and difficult to be considered during differential diagnosis of acute abdomen or sudden maternal collapse in early pregnancy. Therefore, this is a report of mid-trimester triplet's ectopic pregnancy which presented with sudden repeated syncopal attacks and hemodynamic instability that necessitated emergency laparotomy to treat ruptured non-communicating rudimentary horn. The rarity of this clinical condition can lead to multiple challenges. When a diagnosis is confirmed, the intervention plans should be independently tailored based on the patient's age, obstetric history, fertility wishes, as well as, surgeon's experience. Moreover, most cases passed unnoticed till complications took place. Thus, early diagnosis of Mullerian anomalies preconceptionally or even during the initial antenatal visits is crucial step regarding the avoidance of such catastrophic maternal outcomes.

Key words: second trimester; ectopic pregnancy; mullerian anomalies; rudimentary horn; unicornuate uterus

Ginekologia Polska 2020; 91, 9: 569–570

CASE REPORT

A 25 years old woman G2P1 + 0 presented gestation to emergency unit of Benha University Hospital at 20 weeks complaining of sudden onset of acute abdominal pain and repeated syncopal attacks. By history, she had no unusual medical or surgical history. She delivered uneventfully three years prior. After a period of secondary infertility, she was prescribed ovulation induction in the form of clomiphene citrate three months before the current pregnancy. Cervical cerclage by the end of first trimester after being diagnosed as triplet pregnancy.

By general examination, she was drowsy with extreme pallor, blood pressure 90/60 mmHg, pulse 120–130 beat per minute, respiratory rate 29 per minute and no fever. Upon abdominal examination, generalized tenderness and rebound tenderness all over the abdomen with shifting dullness on percussion. A pelviabdominal ultrasound revealed marked free intraperitoneal fluid collection, three dead fetuses 20 weeks gestation by biometric measurements with an empty uterus. Her immediate laboratory results showed hemoglobin level of 5 gm/dL with satisfactory kidney and liver function tests without evidence of coagulopathy.

It was explained precisely to the couple that she was most likely suffering from uterine rupture which needed immediate intervention after cross-matching of packed RBCs and other blood products required accordingly. They signed a clearly informed, high-risk consent form after full counselling about the management modalities, as well as, the risks and the complications.

AneEmergency laparotomy was performed through pfannensteil incision. The findings were marked hemoperitoneum with three dead fetuses, ruptured non-communicating rudimentary horn and intact empty unicornuate uterus. An excision of the rudimentary horn was done at the line of contact with the unicornuate uterus. Multiple U-shaped sutures with vicryl-1 were held to ensure hemostasis. (Fig. 1) Two drains were inserted intraperitoneally and subrectally, then a mass closure of abdominal wall was adequately completed.

The patient received three units of packed RBCs, six units of plasma and NovoSeven ® RT (recombinant coagulation Factor VIIa) intra-operatively, then she was transferred to ICU for close monitoring. She received 12 units of platelets and cryoprecipitate. After two days, she became fully conscious with improvement of her laboratory results, so she was discharged from ICU to the ward. She was finally discharged home three days later in good condition with an appointment for follow up in the outpatient clinic. She was offered combined oral contraceptive pills as birth control for at least 18 months before planning subsequent pregnancy.

The infrequent detection of unicornuate uterus (nearly 1:100,000 women), which is a result of Mullerian duct fusion defect, makes its diagnosis challenging as the presentation varies from being asymptomatic to sever obstetric hemorrhage.

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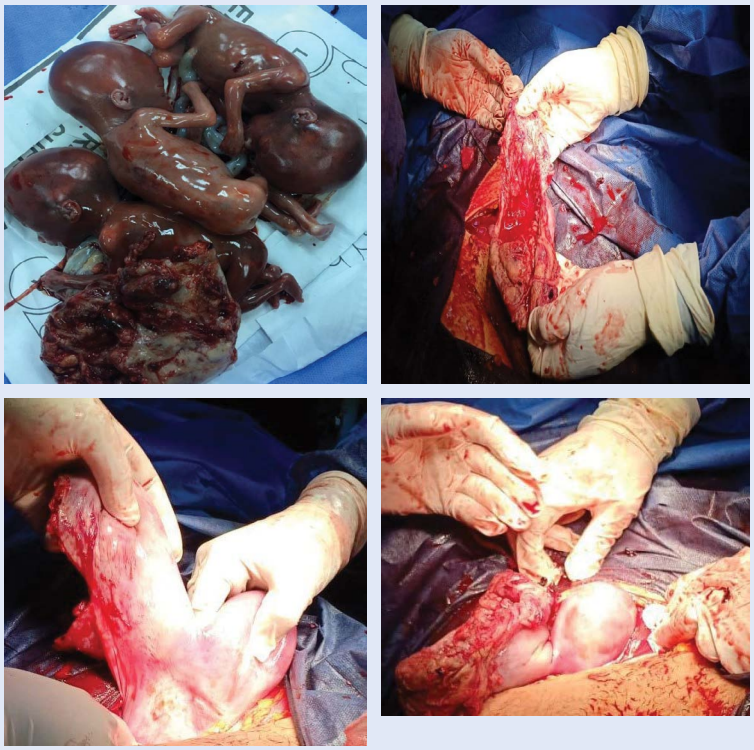

Figure 1. Showing three dead fetuses, ruptured non-communicating rudimentary horn, unicornuate uterus and treatment by excision

Moreover, when a pregnancy takes place within non-communicating rudimentary horn, as rare instance (1:76,000 pregnant women), the condition might worsen. It was explained hypothetically by relocation of the sperm or the fertilized oocyte trans-peritoneally from the contralateral tube or through a minute tract within the unicornuate uterus's walls.

Early diagnosis of unicornuate uterus is difficult due to the fact it is mostly asymptomatic and its discovery is mainly incidental during work-up of infertility, pelvic pain or recurrent miscarriage or unfortunately during the second trimester when uterine rupture is most likely to complicate pregnancy. Thus, the condition is rare and mostly diagnosed throughout complication. It must be kept in mind during preconception evaluation and early antenatal booking visit to avoid unexpected outcomes [1–3].

Conflict of interest

The authors report no conflicts of interest.

REFERENCES

1. Management of Acute Obstructive Uterovaginal Anomalies: ACOG Committee Opinion Summary, Number 779. Obstet Gynecol. 2019; 133(6): 1290–1291, doi: 10.1097/AOG.0000000000003282, indexed in Pubmed: 31135759.
2. Ludwin A, Lindheim SR. Unicornuate uterus and the noncommunicating functional horn: continued debate on the diagnosis, classification, and treatment. Fertil Steril. 2020; 113(4): 772–773, doi: 10.1016/j.fertnstert.2020.01.006, indexed in Pubmed: 32147179.
3. Obeidat RA, Aleshawi AJ, Tashtush NA, et al. Unicornuate uterus with a rudimentary non-communicating cavitary horn in association with VACTERL association: case report. BMC Womens Health. 2019; 19(1): 71, doi: 10.1186/s12905-019-0768-4, indexed in Pubmed: 31146728.