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A Case of Recurrent Pregnancy Loss due to Bicornuate Uterus

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**Clinical History**

30 year old G10 P4 L2 A5 D2 came with h/o 1.5 months of amenorrhoea with c/o bleeding PV since 2 weeks a/wpain, c/o fatigue since 2 days.

**History of present pregnancy :** 1st trimester – conceived spontaneously, pregnancy detected by UPT 1 week back, confirmed by USG.

**Obstretic History**

G10 P4 L2 A5 D2

1st – conceived spontaneously, breech delivery, male died at 22 days. Cause of death – jaundice

2nd- conceived spontaneously, spontaneous abortion at 2 months, D&C done

3rd – conceived spontaneously, spontaneous abortion at 2.5 months

4th – conceived spontaneously, spontaneous abortion at 1.5 months

5th – conceived spontaneously, spontaneous abortion at 3 months

6th – conceived spontaneously, cervical encerclage at 4th month, FTND, female baby died at 2 years. Cause of death – Tuberculosis

7th – conceived spontaneously, FTND, female baby, 9 years of age, currently active and healthy

8th – conceived spontaneously, FTND, female baby, 8 years of age, currently active and healthy.

9th – conceived spontaneously, consumption of MTP pills at 1.5 months, complete abortion.

10th – conceived spontaneously, present one.

**Menstrual history:**

LMP – 9/3/19

EDD – 16/12/19

POG – 6 weeks 2 days

Past cycles – 3-5/30, regular, moderate flow, No pain , No clots.

H/o of Laproscopic sterilization done in 2011 and 2015

**Examination:**

GENERAL PHYSICAL EXAMINATION:

Pulse – 84 bpm

BP – 130/80 mm Hg

Pallor absent

SYSTEMIC EXAMINATION :

CVS – S1, S2 heard. No murmurs

RS – B/L normal vesicular breath sounds heard. No added sounds

P/A – Soft, non tender. No organomegaly

P/S – No discharge, cervix healthy

P/V – uterus bulky, corresponds to 8 weeks size.

**Investigations:**

**Hb** – 12.4gm/dl (12-15 gm/dl)

**TLC** – 11410 cells/cumm (4000 – 11000 cells/cumm)

**DC:** Neutrophils – 59.1

**Lymphocytes** – 34.9

**Eosinophils** – 1.6

**Monocytes** – 4.1

**Basophils** – 0.3

**PCV** – 38.9 (36-46%)

**Rbc count** – 5.08 million/cumm (3.8-4.8 million/cumm)

**Diagnosis:**

1. Chromosomal abnormality
2. Inherited thrombophilias
3. Anti -phospholipid antibody syndrome
4. Poorly controlled diabetes
5. Thyroid autoantibodies
6. Luteal phase defect
7. Polycystic ovarian syndrome

**Diagnosis:**

30 Year old Gravida 10 Para 4 Living 2 Abortion 5 Death 2 with 6 weeks 2 days of gestation with Bicornuate Unicollis Uterus with implantation in the left horn.

## **Treatment:**

### Procedure:

MTP with Laproscopic bilateral salpingectomy under GA.

### Laprosopic findings:

Bicornate Unicollis uterus noted

Right hydrosalpinx noted

Fallope rings of old tubectomy present on the right tube

Left tube not tubectomized

Bilateral salpingectomy done

### Per-operative findings:

Products of conception present in the left horn

6 weeks size uterus noted

Products sent for HPE.

## **Discussion:**

Congenital uterine anomalies result from the abnormal formation, fusion, or resorption of Müllerian duct during fetal life.

They are present in, 2–8% of infertile women, and 5–30% of women with a history of miscarriage(1). Premature deliveries (29%), spontaneous first-trimester abortions (24%), ectopic pregnancies (3%), abnormal fetal presentations (23%) and a high cesarean section rate (27.5%) occurred in those patients.

In 30% of the patients, cervical incompetence was diagnosed. Improved obstetric outcomes occurred in patients treated with cervical cerclage(5).

Although uterine anomalies are associated with adverse reproductive outcomes, healthy reproductive outcomes are possible.

Females with obstructive uterine anomalies tend to present during adolescence due to pelvic pain or dysmenorrhea, and those with non obstructive uterine anomalies may not be identified until evaluation of pregnancy loss, an obstetric complication, or infertility is initiated.

Imaging modalities to evaluate congenital uterine anomalies include two-dimensional ultrasonography (2DUS), three-dimensional ultrasonography (3DUS), hysterosalpingography, saline infusion ultrasonography, and magnetic resonance imaging (MRI).

As 3DUS is increasingly utilized in pelvic imaging, this modality is proving to be highly accurate in diagnosing uterine anomalies and may be equivalent to MRI(2).

Widely diverging horns seen on HSG may suggest a bicornuate uterus and an intercornual angle greater than 105 degrees suggests bicornuate uterus, whereas one less than 75 degrees indicates a septate uterus. However, MRI may be necessary to define fundal contour.

With this, an intrafundal downward cleft measuring greater than or equal to 1 cm is indicative of bicornuate uterus, whereas a cleft depth < 1 cm indicates a septate uterus(9)

Over the years, surgical treatments have been offered to women diagnosed with congenital uterine anomalies.

Abdominal metroplasty is associated with significant morbidities, such as prolonged hospital stay, long post-op recovery, intra-abdominal adhesions, uterine rupture in subsequent pregnancies etc.(3) Strassman metroplasty provides an important decrease in the percentage of fetal loss (8-12%) compared to patients without surgical treatment (70-96%).(7) It is a unification procedure performed to correct the two smaller uterine cavities into a more spacious single cavity. Improved reproductive performance was reported after unification metroplasty. Laparoscopic route can be adopted for this procedure with all the advantages of minimally invasive surgery. The laparoscopic route provides better magnification, lower tissue drying, reduced infections, lesser adhesions, shorter hospital stay,

and quicker recovery. (6) The actual benefit of metroplasty for a bicornuate uterus, however, has not been tested in a controlled clinical trial and metroplasty for now should be reserved for women in whom recurrent pregnancy loss occurs with no other identifiable cause(8). According to the CREST study, the 10-year failure rate is 18.5 per 1000 procedures. The pregnancy rates were highest following laparoscopic Hulka clip sterilization and lowest following monopolar coagulation and postpartum salpingectomy (4)



USG abdomen of bicornuate uterus  
<https://radiopaedia.org/articles/bicornuate-uterus>



HSG of bicornuate uterus  
<https://radiopaedia.org/cases/bicornuate-vs-septate-uterus?lang=us>

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