UTERUS DIDELPHYS ASSOCIATED WITH UNILATERAL HAEMATOCOLPOS AND IPSILATERAL RENAL AGENESIS A CASE REPORT

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INTRODUCTION

The earliest case of uterus didelphys with unilateral haematocolpos was reported by Wilson (1) in 1925. A 14 year old girl who had regular menses for 4 months had severe intramenstrual pain. Vaginal examination revealed a cervix above a left vaginal swelling. This swelling was continuous with the uterus. A diagnosis of sarcoma of the uterus was made. At laparotomy, there were two uteri, the left larger than the right on top of the swelling 3" × 2½" × 2". There were two fallopian tubes and a normal right ovary. On hemisection the wall of the cystic swelling was found to be filled with material typical of a haematocolpos.

This was followed by individual reports from various authors (2-6).

Simon (2) reviewed 23 cases of haematometra and found 8 cases of uterus didelphys with unilateral gynaetresia.

Brown and Brews (3) reviewed 50 cases of congenital retention of menses. They found only one case of a girl of 16 years with abdominal tumour up to the umbilicus. Laparotomy followed by excision of the hymen was performed but she died of sepsis.

Embrey (4), Merckel (5) and Chew (6), had similar cases of unilateral haematocolpos with uterus didelphys and ipsilateral renal agenesis..

At the Seventh World Symposium of Adolescent and Paediatric Gynaecology at Athens (7), 2 cases were reported with acute abdomen as a result of ruptured haematometra.

The review of this syndrome is to make us more aware of this rare condition so that unnecessary laparotomy can be avoided. Only conservative surgery is required in the management of such a condition in uncomplicated case.

CASE REPORT

A 21 year old single girl gave a history of recurrent offensive vaginal discharge for 6 months associated with suprapubic abdominal pain and backache.

Past History

When she was 14 years old she had dysuria, severe abdominal pain and an abdominal mass. She was diagnosed to have a possible torsion of ovarian cyst. At laparotomy the gynaecologist found a bi-cornuate uterus with the "right horn" filled with 800 ml stale blood. It was thought to be a non-communicating horn of the uterus. An excision of the uterine septum, drainage of the stale blood and ventro-suspension of the uterus was carried out. However, the excision of the septum was incomplete because of its thickness at the lower end.

An intravenous urogram showed agenesis of the right kidney. She was subsequently lost to follow up at the hospital.

In 1983 she was referred as a case of pelvic inflammatory disease to a secnd gynaecologist. She had offensive vaginal discharge for 6 months. Abdominal examination revealed a large cystic mass arisng from the pelvis up to the level of the umbilicus. Vaginal examination revealed a normal cervix and a swelling on the right vaginal wall. The cystic mass could be felt on the right side of the lower abdomen, its lower pole encroaching onto the lower one third of the vagina (Fig. 1).

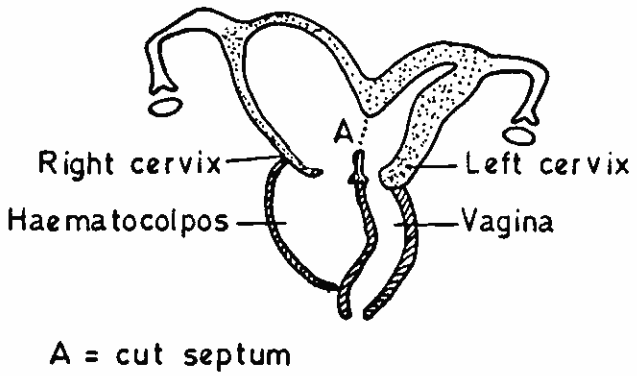

Fig. 1. Double uterus and vagina with cut septum "A" and right-sided haematocolpos.

An ultrasound scan was done. It showed a large cystic mass adherent to the right side of the uterus. It was thought to be a large ovarian cyst or a distended right horn of the uterus filled with blood.

Based on the previous laparotomy findings, the gynaecologist in-charge concluded that the right horn had filled with menstrual blood as a result of incomplete drainage through the cut septum, thus giving rise to subsequent infection.

An examination under anaesthesia was carried out after a course of ampicillin and flagyl. A catheter was inserted through the cervical os upwards via the cut septum to drain the right horn as shown in fig. 2. A litre of foul sero-sanguineous fluid was released. Subsequently she was well, but the mass and the symptoms recurred several months later. A second drainage was done.

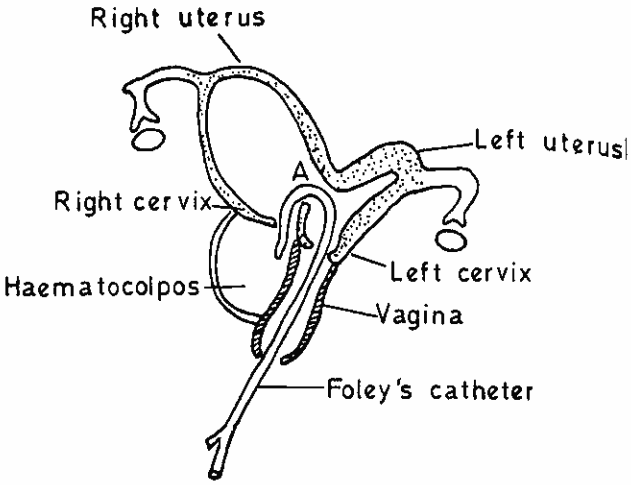

Fig. 2. Drainage of haematocolpos by Foley's catheter through the cut septum "A".

Present admission:

After the second drainage, the patient was referred, this time with the complaint of offensive discharge and supra-pubic pain.

On vaginal examination, the uterus was enlarged to 12 weeks gestational size. A cystic swelling was present in the right vaginal wall and seemed to communicate with the uterus.

Cervix was healthy looking. Dark chocolate fluid was seen per os. (It was 5 days since her menstrual flow). Needle aspiration of the cystic swelling in the right lateral vaginal wall yielded dark chocolate fluid, similar to that seen oozing from the os. The needle puncture was enlarged by a cruciate incision. Copious amount of chocolate fluid was released. On digital examination through the cruciate incision in the vaginal wall, a flat (second) cervix with an os admitting a little finger was felt. This opening was just adjacent to the original cervix as shown in the diagram (Fig. 3).

The cruciate incision was enlarged and marsupialisation of the right vaginal wall was done as shown in fig. 3.

Follow up in the outpatient showed menstrual flow from both cervices at the next cycle. She remains well and has no more offensive vaginal discharge.

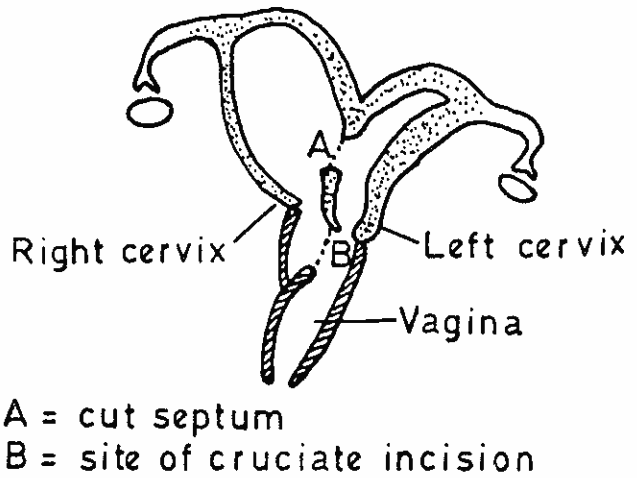

Fig. 3. Excision of vaginal wall with permanent opening "B".

DISCUSSION

A review of the literature showed the difficulty in the diagnosis of this rare clinical syndrome. Often a

laparotomy and a hysterectomy was done before the diagnosis could be made.

The age of the patients described by the various authors varied from 12-17 years. This case first presented as an acute retention of urine at the age of 14 years. The history and clinical findings are similar to that described by Embrey (4) and Chew (6). The other cases presented commonly with severe intramenstrual abdominal pain (after menarche), acute retention of urine and a unilateral pelvic mass.

With the advent of ultrasonography, Rosenberg et al (8) described the use of ultrasound to diagnose the duplication of the uterus and vagina with unilateral hydrometrocolpos and ipsilateral renal agenesis pre-operatively. However, we could not get such a clear picture from our ultrasound scan.

Ideally a cruciate incision over the cystic swelling in the vagina would release the stale blood dammed by the imperforate hymen on the right side of the vagina (as in this case). The cruciate incision should be enlarged and marsupialised so that there is a patent opening. Normal menstruation occurs from both uteri and can be seen through the two cervical os. It would be interesting to follow her progress in pregnancy when it occurs.

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NOTICE

Because of financial constraints, we are combining No 4 and 5 issues in this single copy. We hope this is only temporarily and we will be able to publish seven issues per year when the financial climate improves.

The Editor

19th Annual Combined Surgical Meeting 28th November — 1st December 1985

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Prostatic Cancer

Young Surgeon Award

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ERRATUM

THE AETIOLOGY OF URETHRAL DISCHARGE IN MEN
SINGAPORE MEDICAL JOURNAL, June 1985, Vol 26
No. 3; Pg 279-82.

Table 4 of the above article should read as follows:-

FREQUENCIES OF RECOVERY OF OTHER POTENTIAL PATHOGENS FROM 73 MEN WITH GONOCOCCAL URETHRITIS

	Total	Day 1	Day 14
C. trachomatis	11	4	7
Mycoplasma	5	4	1
C. trachomatis + Mycoplasma	2	1	1
Mycoplasma + C. albicans	2	1	1
C. trachomatis + Mycoplasma + C. albicans	1	1	—
C. albicans	4	1	3
Total	25	12	13