

Case Report on Septate Uterus: An Incidental Finding in a Multiparous Woman who Had an Emergency Cesarean Section

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ABSTRACT

Background: Septate uterus is caused by incomplete resorption of the Mullerian duct during embryogenesis which may alter the reproductive outcome of the patients. It is the commonest form of structural uterine anomaly and has the highest reproductive failure rate. **Case Report:** A 21-year-old booked G₄P₂⁺¹ woman with two living male children admitted into the Antenatal ward through the Accident and Emergency ward at 33 weeks gestation for conservative management of preterm premature rupture of membrane. She had a previous history of miscarriage, preterm delivery, and elective caesarean section due to breech presentation in her first, second, and third pregnancies in 2007, 2008, and 2009, respectively. She, however, had an emergency caesarean section due to fetal distress at 33 weeks plus 4 days with the delivery of a live female baby that weighed 2.0 kg with APGAR scores of 7 and 8 in the 1st and 5th minutes, respectively. There was intraoperative finding of septate uterus with dimple at the fundus. The other abdominal viscera were normal. **Conclusion:** congenital uterine anomalies especially septate uterus, though rare, should be suspected in women with positive history of miscarriage, preterm delivery and malpresentation.

KEY WORDS: Asia, fetal distress, multiparous, preterm, septate, uterus

INTRODUCTION

Septate uterus is caused by incomplete resorption of the Mullerian duct during embryogenesis which may alter the reproductive outcome of the patients. The average incidence of uterine defects in the general population and in infertile women is 4.3% and it increases to 5%-25% in women with recurrent pregnant loss.^[1-3] The septate uterus, accounting for about 55% of Mullerian duct anomalies, is the commonest form of structural uterine anomaly and has the highest reproductive failure rate.^[4,5]

It is because of this that a case report on septate uterus, an incidental finding in a multiparous woman who had an emergency caesarean section, is necessary.

CASE REPORT

Mrs NC, a 21-year-old booked G₄P₂⁺¹ woman with two living male children admitted into the Antenatal ward through the Accident and Emergency ward at 33 weeks gestation on

account of preterm premature rupture of membrane. The fetal and maternal vital signs were normal. Urgent obstetric ultrasound scan revealed a viable singleton intrauterine gestation in longitudinal lie and cephalic presentation. There was adequate gross body movement, and the fetal heart rate was 138 beats per minute. There was also oligohydramnios and placenta was posterior-fundal. Other abdominal viscera were sonologically normal. She was put on conservative management with close fetal and maternal monitoring. Two doses of dexamethasone 12 mg 12 hourly as well as prophylactic antibiotics (erythromycin and metronidazole) and haematinics were given to the patient. Her obstetric history showed that she had miscarriage in her first pregnancy at 18 weeks gestation in 2007. She had preterm labor in 2008 at 32 weeks gestation with the delivery of a live male baby at a primary health center. The baby was transferred to a tertiary hospital where he was nursed at newborn unit for 4 weeks before discharge. She also had elective caesarean section due to breech presentation at 38 weeks in Enugu State University of Science and Technology (ESUT) Teaching Hospital, Park Lane, Enugu, in 2009 with the delivery of a live male baby.

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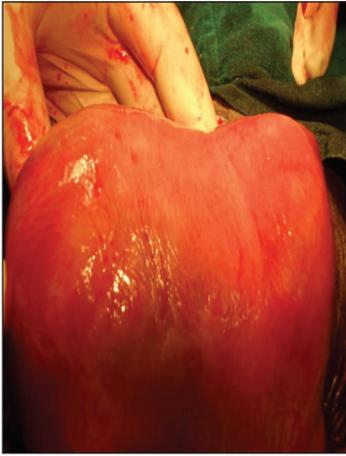


Figure 1: The antero-fundal view of the uterus showing the well developed right horn of the fundus, the dimple and poorly developed left horn of the uterus

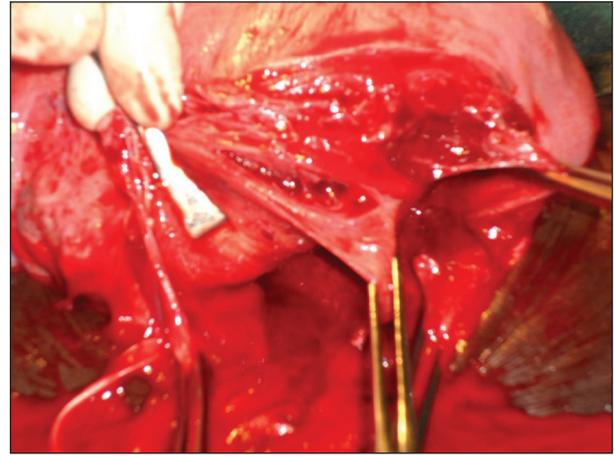


Figure 2: The anterior view of the uterine incision showing the enlarged right uterine cavity which harbored the gestation, incomplete uterine septum extending from the fundus to the corpus uteri and the poorly developed left uterine cavity

At 33 weeks plus 4 days, she had fetal distress for which an emergency caesarean section was done with the following intraoperative findings:

1. Gravid uterus harboring singleton intrauterine gestation in longitudinal lie and cephalic presentation.
2. Dimple at the uterine fundus [Figure 1].
3. A live female baby that weighed 2.0 kg with APGAR scores of 7 and 8 in the 1st and 5th minutes, respectively.
4. Uterine septum extending from the fundus to the corpus uteri [Figure 2].
5. Normal tubes and ovaries.
6. Other abdominal viscera were normal.
7. Estimated blood loss was 300 ml.

The baby was transferred to the Newborn Special Care Unit and discharged after 1 week on admission. The woman did well postoperatively that she was discharged home on her 5th postoperative day. At 6 weeks postpartum, she presented at the postnatal clinic without any complaint. Her menstruation had not commenced. On examination, her vital signs were stable and the systemic examination findings were essentially normal. The baby weighed 4.0 kg and was active and suckling breast milk well. The woman was counseled and referred to family planning clinic. She was discharged from the postnatal clinic.

DISCUSSION

Septate uterus is significantly associated with infertility, miscarriage, malpresentation, and preterm delivery.^[6,7] The clinical presentation ranges from being asymptomatic to complete reproductive failure.^[8] An incidental finding of a uterine septum may sometimes occur during the evaluation of infertility.^[9] There was a previous history of miscarriage,

preterm delivery, and malpresentation in Mrs NC. Uterine septum was incidentally found during caesarean section and there was no history of infertility in our patient. The diagnosis of septate uterus can be achieved with 3D ultrasound scan, hysteroscopy, magnetic resonance imaging (MRI), and hysteroscopy which is the gold standard.^[9,10] The obstetric ultrasound scan done on our patient could not detect the septate uterus. Septate uterus is corrected through the resection of the septum usually with the aid of a hysteroscope. This was not done for Mrs NC.

In conclusion, congenital uterine anomalies vis a vis septate uterus, though rare, should be suspected in women with positive history of recurrent miscarriage, preterm delivery, and malpresentation.

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