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Didelphys uterus with recurrent preterm labour: case report

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Müllerian anomalies (MAs) are congenital defects of the female genital tract due to failure of development of the Müllerian ducts, which normally occur in utero between 6 and 22 weeks [1].

The prevalence of MAs is about 4.3% in the general fertile population, 3.5% in the infertile population, and 13% in women with recurrent pregnancy losses (RPL) [2].

Septate uterus is the commonest type of MA (35% incidence), followed by bicornuate uterus (25% incidence), and arcuate uterus (20% incidence) [1].

Women with MAs are at risk of adverse pregnancy outcome, including recurrent pregnancy loss (RPL), low birth weight, preterm labour (PTL), malpresentation, and increased caesarean section rate [3, 4].

A 32-year-old woman, with one previous caesarean section (CS) at 35 weeks' gestation due to didelphys uterus (Figure 1) diagnosed during the first caesarean section, presented with recurrent PTL at 34 weeks +2 days, and breech presentation after uneventful antenatal care.

The PTL was diagnosed by regular uterine contractions ≥ 4 contractions/30 min, each contraction lasting > 30–45 s, with significant cervical changes on digital examination (cervical dilatation > 4 cm and > 50% effacement) [5].

During the antenatal care dexamethasone and magnesium sulphate ($MgSO_4$) were given to the studied woman at 28 weeks' gestation for foetal lung maturity and neuroprotection, respectively, because of risk of recurrent PTL (previous PTL and MA) [6–8].

The studied woman was given pre-operative prophylactic antibiotics according to the hospital protocol after exclusion of urinary tract infection, sexually transmitted diseases, and group B streptococcus infection [9]. She delivered by CS due to breech presentation a live baby boy, 2.230 kg, with an Apgar score of 7, 8, and 9 at 1, 5, and 10 min, respectively. The studied woman and her neonate were discharged from the hospital on the third postoperative day in good general condition.

Didelphys uterus occurs due to complete failure of fusion of the two Müllerian ducts, leading to two separate uterine cavities, two cervices, and two vaginas separated by a longitudinal vaginal septum [1].

Didelphys uterus is the least common type of MA, and it occurs in 8.3% of cases [1]. Didelphys uterus is suspected when the routine speculum examination showes two vaginal orifices separated by a longitudinal vaginal septum [1, 3].

A 2D ultrasound is usually used as the first imaging tool for diagnosis of MA followed by 3D ultrasound as a confirmatory tool [1, 3].

Magnetic resonance imaging (MRI) is an accurate tool in diagnosing MAs as hysterosalpingogram, hysteroscopy, and laparoscopy [1].

MAs are frequently associated with Wolffian duct anomalies (anomalies of the urinary tract) [1]. Vaz *et al.* concluded that MAs are associated with adverse fertility, and pregnancy outcomes in the form of RPL, low birth weight, PTL, malpresentation, and increased CS rate [3].

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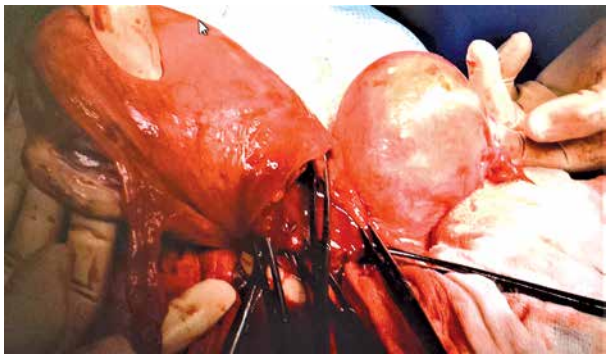

Figure 1. Intra-operative image during the caesarean section shows the didelphys uterus

In addition, Khander *et al.* concluded that women with MAs and prior PTL are at risk of recurrent PTL [10].

Similarly, the studied case had a history of PTL at 35 weeks and presented with recurrent PTL at 34 weeks +2 days, and delivered by CS for the second time due to breech presentation.

In conclusion, didelphys uterus is the least common type of Müllerian anomaly, and it occurs in 8.3% of cases. Women with didelphys uterus and Müllerian anomalies are at risk of preterm labour, malpresentation, and increased CS rate.

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Conflict of interest

The authors declare no conflict of interest.

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