CASE REPORT

A CASE REPORT ON SEPTATE UTERUS

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HOW TO CITE THIS ARTICLE:

Vasudha, Anitha, Syamala, Usharani. "a Case Report on Septate Uterus". Journal of Evolution of Medical and Dental Sciences 2013; Vol2, Issue 37, September 16; Page: 7103-7106.

ABSTRACT: A septate uterus is a type of congenital uterine anomaly. It is classified as a class V Mullerian duct anomaly. It is considered the commonest uterine anomaly (accounts for upto ~ 55% of such anomalies) and is the most common anomaly associated with reproductive failure (in 67%). Here is a case report of a patient who presented with primary infertility. Hystero-laprosocopy was done and diagnosed to have septate uterus for which septal resection was done. Following which patient conceived and delivered.

KEYWORDS: septate uterus, infertility, septal resection

INTRODUCTION: The septate uterus is the most common müllerian anomaly, accounting for 55 % of detected uterine anomalies. It consists of a single uterus divided by a large fibrous midline septum. If the septum extends upto the internal os of the cervix or even further downward, it is considered a complete septum. If it does not and remains halfway through the cavity, the uterus has a partial septum and is called "subseptate." In addition, a septum may be broken up longitudinally, or segmented ⁽⁴⁾. The external contour of the uterine fundus may or may not be indented, but the groove does not exceed 1.5 centimetres in depth. In the female embryo, uterine development is usually complete by 22 weeks' gestation, with the two müllerian ducts fusing together to form a single uterus. In one of the final events of uterine formation, the wall where the ducts fused dissolves, forming a single endometrial cavity. It is the failure of this last process that produces a septate uterus with two endometrial canals, reflecting either a partial or complete failure of the duct walls to dissolve, depending on the extent of the septum. .

CASE REPORT: 33 year nulliparous lady married for 3 ½ years, presented to the clinic as she was anxious to conceive. Patient and her partner were evaluated for the same. Investigations revealed polycystic ovaries . Semen analysis was normal. Hysterosalpingogram done showed bicornuate uterus with bilateral free spill of the dye .Patient was stimulated for ovulation induction and Intra uterine insemination was done thrice which failed. Following that diagnostic hystero-laprosocopy was done, which showed a broad fundus. Hysteroscopy showed thick septum extending from the fundus to the internal os. Both ostia visualized. Total resection of septum was done. The procedure was performed using a cutting monopolar 90°-angle knife electrode. The cutting current was set to 50-70 W. The uterine cavity was distended with 1.5% glycine at an inflow pressure of 70-100 mmHg. The septum was divided in an upward direction until both tubal ostia were equally visible. After division of the septum, uterine pressure was decreased and hemostasis was confirmed. Chromotubation done bilateral free spill was present. Hysterosalpingogram was repeated after 3 months duration which showed that uterine cavity was normal.

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Hysterosalpingogram before and after the septal resection

Patient conceived with ovulation induction and Intra uterine insemination after 1 year. At 13 weeks of gestation prophylactic cervical encirclage was done. Then patient was called for routine antenatal checkups. All trimesters were uneventful. Patient underwent elective lower segment caesarean section at 38 weeks on maternal demand and precious pregnancy. She delivered a boy baby of 3.06 kg. During the caesarean section cavity was found to be normal.

Cavity during caesarean section

DISCUSSION: Septate uterus considered a type of uterine duplicational anomaly and results from partial or complete failure of resorption of the uterovaginal septum after fusion of the paramesonephric ducts. The septum is usually fibrous but can also have varying muscular components. The external uterine contour may be convex, flat, or mildly ($< 1\text{cm}$) concave.

Hysterosalpingogram findings: Accuracy of hysterosalpingogram alone is 55 % for differentiation of septate from bicornuate uteri. An angle of less than 75° between the uterine horns is suggestive of a septate uterus, and an angle of more than 105° is more consistent with bicornuate uteri ^(1,2).

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Unfortunately, the majority of angles of divergence between the horns fall within this range, and considerable overlap between the two anomalies is noted ⁽³⁾.

Complications: 90% miscarriage rate

- a septate uterus is associated with the worst obstetric outcome of the Müllerian duct anomalies.
- Patients with septate uteri usually do not have difficulty conceiving, but the pregnancies frequently end in abortion or premature birth.

Treatment and prognosis: The distinction between septate and bicornuate uterus has important management implications. In septate uterus, but not in bicornuate uterus, the septum can be shaved off during hysteroscopy to form a single uterine cavity without perforating the uterus ⁴.

Reproductive outcome has been shown to improve after resection of the septum, with reported decreases in the spontaneous abortion rate from 88 to 5.9% after hysteroscopic resection ⁽⁵⁾.

Hysteroscopic repair has become the most popular method for the management of septate uterus. The advantages of this method include less morbidity, no abdominal or trans myometrial incisions, and a shorter time until the patient can return to normal activities ⁽⁷⁾. Because no abdominal incision is made in this method, possible infections and intraabdominal adhesions that may cause future fertility problems or pain are avoided. Pregnancy can also be planned sooner after the hysteroscopic approach than after abdominal procedures ⁽⁹⁾.

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Date of Submission: 02/09/2013.
Date of Peer Review: 03/09/2013.
Date of Acceptance: 04/09/2013.
Date of Publishing: 12/09/2013