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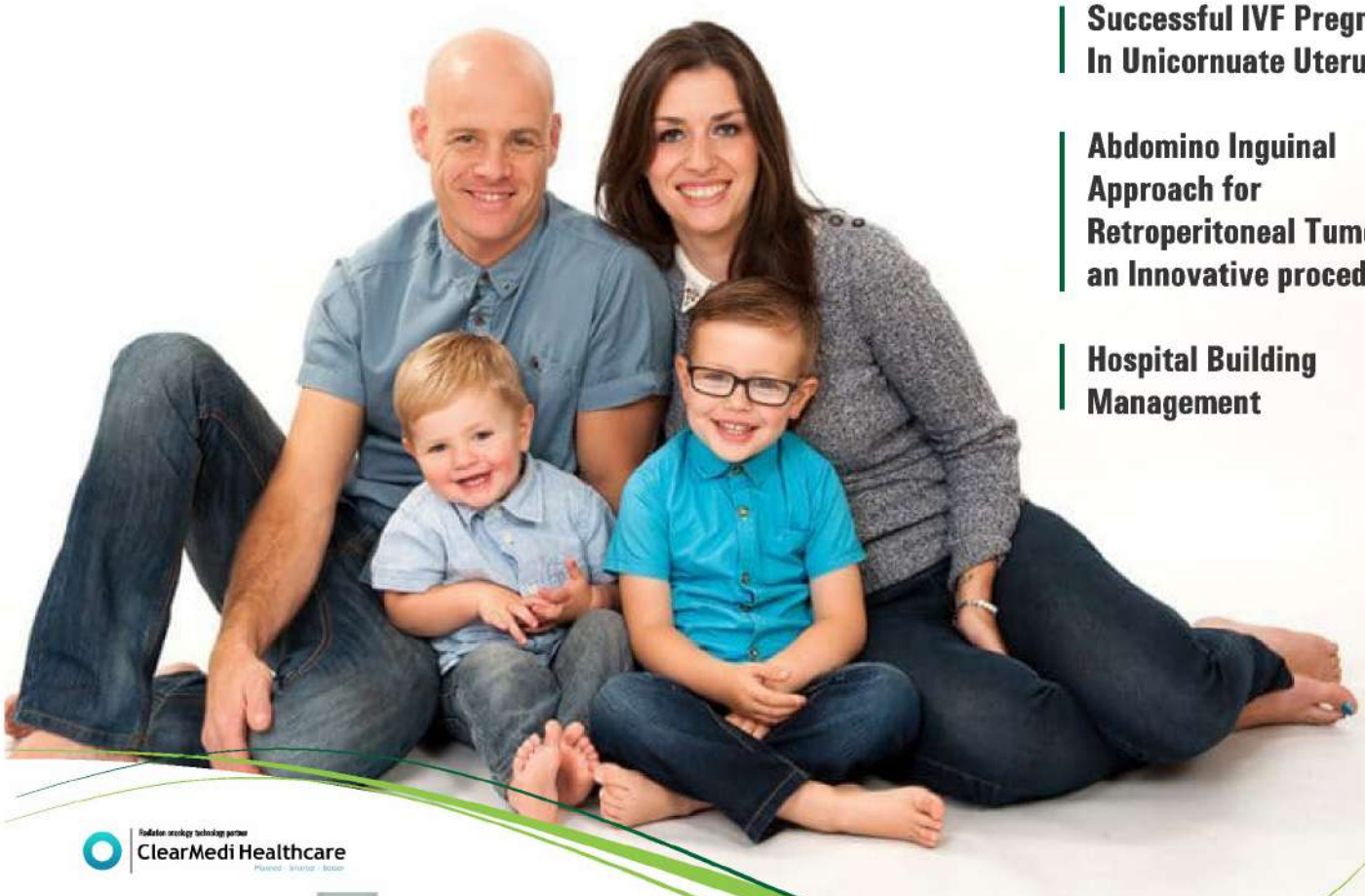

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SUCCESSFUL IVF PREGNANCY IN UNICORNUATE UTERUS

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INTRODUCTION

Uterine malformations are rare congenital abnormalities located within the female genital tract. The incidence of uterine malformation has been reported to be between 0.1 and 3% (Lee et al., 1999). However, the incidence rate is not well defined, as many patients with this condition are asymptomatic.

Malformation of the uterus has already been recorded, according to Buttram and Gibboons (1979). A new classification system based on the degree of abnormal development was used to separate the anomalies into groups. Numerous characteristics were evaluated, including uterine absence and the presence of a unicornuate uterus, rudimentary uterine horn, blind uterine horn, and symmetrical double uterus.

Unicornuate uteri are classified into four groups by the American Society of Reproductive Medicine (ASRM) as:

(1) a unicornuate uterus with a communicating rudimentry horn; (2) a unicornuate uterus with a non-communicating rudimentary horn; (3) a non-cavitated unicornuate uterus with a non-communicating rudimentary horn; and (4) an isolated unicornuate uterus (The American Fertility Society, 1988). The unicornuate uterus with non-communicating rudimentary horn is the most common type. Complications of the rudimentary horns include endometriosis, primary infertility, hematometra, and associated renal anomalies (Kadan and Romano, 2008). The symptoms do not appear until menarche. Alternatively, the presenting symptoms may be non-specific. For these reasons, the diagnosis is often made late. As a result, the diagnosis of complications is also late (Liatsikos et al., 2010).

CASE HISTORY

42 year old patient came with a c/o infertility. She had regular cycles in the past. She attained menopause 1 year back. No past history of dysmenorrhoea. An ultrasound revealed a right sided uterus and a homogenous mass. Both ovaries were small. Her ovarian reserve was poor. Hystero salpingogram showed unicornuate uterus. Diagnostic hysteroscopy also confirmed right sided unicornuate uterus. Laparoscopy revealed dense bladder adhesions to the fundus of the uterus same released. Right sided unicornuate uterus was diagnosed. Left horn was rudimentary and it was a non communicating horn. So we decided not to remove the horn. She was decided for IVF with donor egg programme. She had triplet conception which spontaneously reduced to twin. Growth of the fetus were monitored. She underwent multifetal pregnancy Reduction(MFPR) to singleton. Fetal growth was monitored. She underwent McDonald cervical encirclage at the end of first trimester. Her anomaly scan was normal. LSCS was done at term, delivering 2.4kg breech baby.

DISCUSSION

At 6 weeks a pair of mullerian duct appeared, this worked their way down to the inside of the fallopian tubes during development. The Müllerian ducts met at eight weeks. The fused Müllerian nodules at the lower center were formed by the junction of two round ligaments. Above this, the Mullerian duct walls appeared with a combined center at around 16 weeks, and the uterus was formed (Baker et al., 1953).

In congenital anomalies of the uterus, Mullerian duct fusion did not occur properly, or the septum was not fused. Depending on the degree of absorption, anomalies occurred in various forms. The incidence of this anomaly was 0.17% (1 in 594) in women of childbearing age. However, the rate (3.5% or 1 in 29) was higher among relatively infertile women.

The distribution of uterine anomalies has been reported as follows: arcuate type 7%, uterine septum 34%, bicornuate uterus 39%, didelphys 11%, unicornuate uterus 5%, and segmented Mullerian duct institutions hypoplasia 4%. Some congenital uterine anomalies are known to be more common (Nahum, 1998). This is similar to uterine Mullerian duct anomalies, in that patients who display clinical

symptoms are more likely to be identified (Bakri et al., 1992).

The most common complications include endometriosis, dysmenorrhea, cervical hematoma, abortion, premature birth, intrauterine fetal growth retardation, and abnormal fetal appearance. The prevalence and knowledge of various types are very important to enable the diagnosis and treatment of gynecological complications.

In general, uterine anomalies present some difficulty in pregnancy retention and overall pregnancy outcome with natural conception and ART.

Arcuate uterus probably has no impact on reproductive capacity. The uterine septum is more definitively associated with recurrent miscarriage, and unlike the bicornuate uterus, surgical correction is technically easier and less morbid. Therefore, in the face of suspect data, surgical repair for the infertile couple with no previous pregnancies seems reasonable. The bicornuate uterus appears to cause an increased miscarriage rate and preterm delivery.

The didelphic uterus was originally thought to have no impact on reproductive outcome, but re-evaluation of the literature shows that it does increase preterm deliveries and miscarriage rates. Like the unicornuate uterus, the didelphic uterus has an increased risk of malpresentation and caesarean section for dystocia. Patients with a unicornuate uterus have the poorest outcome: higher miscarriage rates, higher ectopic rates, higher

Unicornuate uterus after delivary

preterm delivery rates, and lower live birth rates. Pregnancy for vaginal agenesis patients appears comparable with oocyte retrieval from the affected patient and IVF and embryo transfer into a gestational carrier. DES-exposed patients have increased miscarriage, ectopic pregnancies, and preterm delivery rates because of the multitude of associated genital anomalies, not only uterine.

In general, the role of IVF needs to be better evaluated, with studies including a larger number of subjects. IVF pregnancy rates appear to be decreased not because of decreased number or quality of eggs obtained but rather because of the uterine anomaly itself. Resulting implantation rates and clinical pregnancy rates are still uncertain but may be reduced by 50% compared with women undergoing IVF without anomalies.

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