Haematometra and Haematosalpinx caused by cervical obliteration in a bicornuate uterus; case report

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Abstract

This is a case report of a bicornuate uterus with haematometra and haematosalpinx in a Sudanese female. A sixteen years old girl presented with primary amenorrhoea and attacks of lower abdominal pain. Her secondary sexual characters were well developed and the external genitalia looked normal. Abdominal examination was difficult because of tenderness. Ultrasonography showed an enlarged bicornuate uterus with distended Fallopian tubes. The lower part of the cervical canal was obliterated by thin fibrous tissue which was surgically opened. The obstruction was then released and menstrual flow started to drain. This is an unusual case of haematometra and haematosalpinx caused by cervical obliteration.

Introduction

Congenital malformations of the genital tract are not uncommon. Anomalies of the Fallopian tubes are not prominent and frequently go unnoticed. The most frequent uterine anomalies are those resulting from varying degrees of fusion of the Mullerian ducts(10). Estimates of their incidence vary from 0.13 to 0.4 percent. Bicornuate uterus is the most frequent uterine anomaly occurring in over one third of the patients with uterine anomalies. Huffman(7) reported the occurrence of haematometra as a result of congenital anomalies of the vagina but this case is unusual since the haematometra was due to cervical obliteration and the haematometra extended to involve the Fallopian tubes. There is no such case reported in the literature as most cases are due to vaginal anomalies which usually cause haematocolpos(2).

Case report

W.F.A., a girl of sixteen years of age was referred to the gynaecological clinic with history of recurrent lower abdominal pain and primary amenorrhoea. The duration of the pain was five months and the pain was intermittent and present nearly all the time for the last five months. There was no definite pattern but the pain

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increased in frequency with time. The pain was mainly in the suprapubic region, more in the right iliac fossa. She had undergone appendicectomy for that pain two months earlier but without improvement. She was unable to sleep at night because of the pain and was given analgesics and sedatives.

Physical examination revealed that she had a normal built for her age. Her height and weight were within the normal limits. Her secondary sexual characters were well developed inspite of the scanty pubic hair. The breasts were well developed and the external genitalia was normal looking. She was circumcised and this made it difficult to inspect her well.

Abdominal examination showed the scar of appendicectomy and there was marked tenderness and rigidity all over the lower abdomen which made it difficult to feel any mass.

The necessary basic investigations done were normal. Clinical examination did not lead to a definite diagnosis. Ultrasonography revealed a bicornuate enlarged uterus and distended Fallopian tubes.

It was decided to perform examination under anaesthesia to inspect for the cause of the obstruction leading to the haematometra. Under anaesthesia abdominal examination showed the presence of a mass arising from the pelvis to a level of three cm above the symphysis pubis. The mass was slightly deviated to the right iliac fossa. The mass was not mobile which indicated the presence of adhesions. Decircumcision was performed by opening the introitus, thus exposing the vagina. The lower part of the vagina was normal and the hymen was also normal with a central opening. A probe was passed through this opening to about three cm above the hymen. The small finger was then introduced through the hymenal orifice and the cervix was felt. The findings confirmed that there was no abnormality in the vagina causing the obstruction. The opening in the hymen was enlarged and the cervix was exposed and held with a volsellum. The cervical opening was obliterated with fibrous tissue. A uterine sound was used to release the obstruction. After several trials it was possible to open the cervical canal which was obliterated in its lower part only. Immediately dark blood started to drain through the opening. The fluid was allowed to drain freely without any pressure from above until it stopped to drain. Abdominal palpation showed the disappearance of the mass previously felt. It was then decided to repair the decircumcision wound and end the operation. She was put on
prophylactic antibiotics. She had an uneventful post-operative recovery and was discharged from hospital on the fifth day after the operation. She was advised to report for follow up after six weeks or any time she had any problem.

At the first follow up visit she looked quite normal and cheerful. She had concluded her first normal menstrual period without any pain. She had normal night sleep. She came for follow up regularly for six months during which an intravenous pyelogram was done to exclude urinary tract abnormalities. This was normal and she was well.

Discussion

This case is an unusual condition of cryptomenorrhoea where the patient’s menstrual flow did not find its way through the vagina because of the presence of obstruction in the lower end of the cervical canal. This sort of amenorrhea is usually associated with failure of development of the uterus and both Fallopian tubes (3). In this case the uterus was bicornuate and the trapped menstrual blood collected inside it and then extended into the Fallopian tubes thus leading to haematometra and haematosalpinx.

Cases of cryptomenorrhoea are commonly seen as haematocolpos due to abnormalities in the vagina such as transverse vaginal septa. Cases of congenital anomalies of the genital tract are usually associated with abnormalities of the urinary tract and this is why an intravenous pyelogram was important to do.

In such a case it is important to do a hystero-salpingogram when she gets married and the issue of reproduction arises. There is the possibility of adhesions due to the previous appendectomy and this might have caused blockage of the Fallopian tubes.

References