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Case Study

A Rare Case of Uterus Didelphys Diagnosed in a Primigravida Woman

Amritha Krishna, Jeffnisha J., Drishya L.,* Shaiju Dharan

Ezhuthachan College of Pharmaceutical Sciences, Marayamuttom, TVM, Kerala.

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ABSTRACT

Uterus didelphys is a rare congenital Müllerian duct anomaly characterized by complete duplication of the uterus and cervix. It is often asymptomatic and may remain undiagnosed until pregnancy or evaluation for reproductive concerns. We report the case of a 33-year-old primigravida who presented at 3 weeks of gestation for routine antenatal evaluation. First trimester obstetric ultrasonography revealed two completely separate uterine cavities with two distinct cervices, confirming the diagnosis of uterus didelphys. The patient had no prior history of abortion or significant drug exposure. She was managed conservatively with folic acid and progesterone supplementation and was counselled regarding potential obstetric risks, including preterm birth, fetal growth restriction, and the possibility of cesarean delivery. Early diagnosis and appropriate antenatal care are essential in optimizing maternal and fetal outcomes in such cases.

INTRODUCTION

Congenital uterine anomalies arise due to abnormal development, fusion, or resorption of the Müllerian ducts during embryogenesis. Uterus didelphys is a rare anomaly resulting from complete non-fusion of the Müllerian ducts, leading to duplication of the uterine horns and cervices.

Although many women remain asymptomatic, this condition is associated with adverse reproductive outcomes such as recurrent pregnancy loss, preterm labor, malpresentation, and increased cesarean section rates. Early detection during pregnancy plays a crucial role in risk stratification and management. This case highlights the incidental diagnosis of uterus didelphys in a primigravida during early pregnancy.

Case Presentation

A 33-year-old female presented to the obstetrics outpatient department with a history of missed menstrual period with LMP 06.12.25 and confirmed early pregnancy of approximately 3

***Corresponding Author:** Drishya L.
Address: *Assisstant Professor, Ezhuthachan college of Pharmaceutical Sciences, Marayamuttom, TVM, Kerala*
Email ✉: amrithakrishna797@gmail.com

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weeks. This was her first pregnancy (primigravida).

She had no history of previous abortions, infertility, or menstrual irregularities. There was no significant past medical or surgical history. The patient also denied any history of chronic medication use, teratogenic drug exposure, smoking, or alcohol intake.

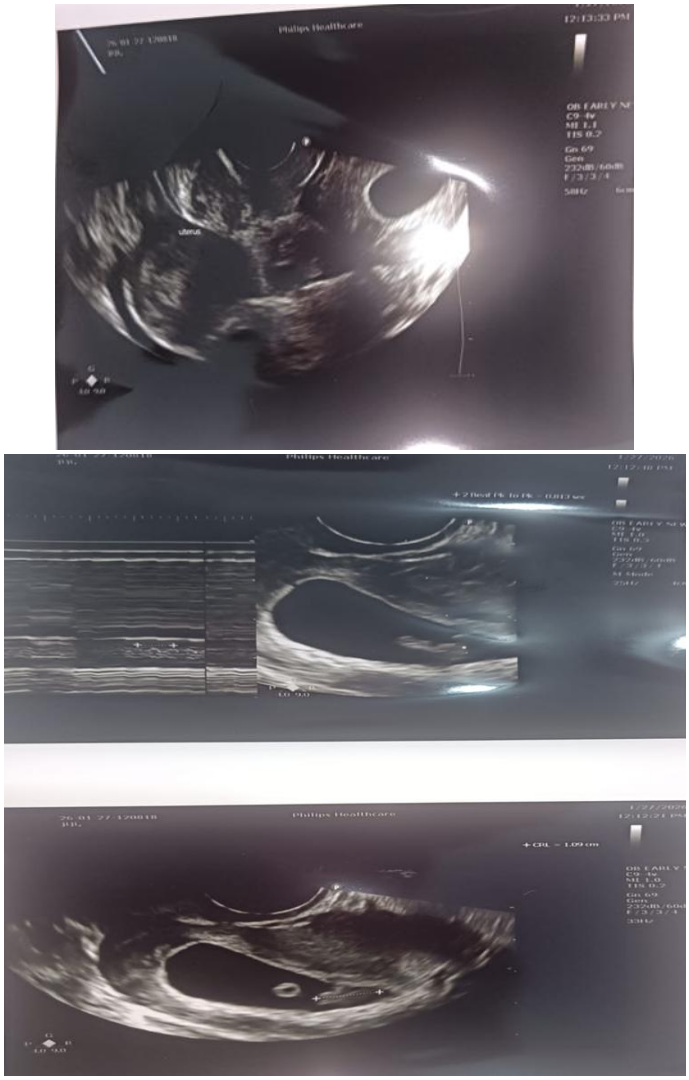
On general physical examination, the patient was stable, and vital parameters were within normal limits. Systemic examination revealed no abnormalities.

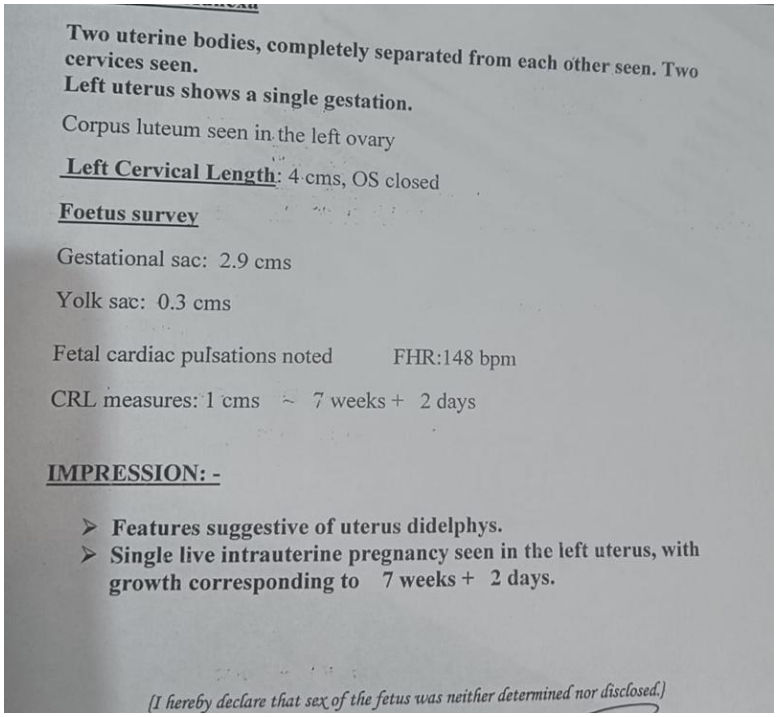
Laboratory parameters done which include Hb, Differential Count, LFT, RFT, URE, Blood grouping, Thyroid profile.

First trimester obstetric ultrasound scan was performed, which revealed:

- Presence of two completely separate uterine bodies
- Two distinct endometrial cavities
- Two cervices, confirming duplication
- Early intrauterine pregnancy noted
- These findings were consistent with a diagnosis of uterus didelphys

Investigations





Two uterine bodies, completely separated from each other seen. Two cervices seen.
Left uterus shows a single gestation.

Corpus luteum seen in the left ovary

Left Cervical Length: 4 cms, OS closed

Foetus survey

Gestational sac: 2.9 cms

Yolk sac: 0.3 cms

Fetal cardiac pulsations noted FHR:148 bpm

CRL measures: 1 cms ~ 7 weeks + 2 days

IMPRESSION: -

- Features suggestive of uterus didelphys.
- Single live intrauterine pregnancy seen in the left uterus, with growth corresponding to 7 weeks + 2 days.

[I hereby declare that sex of the fetus was neither determined nor disclosed.]

Management

The patient was managed conservatively with:
Folic acid supplementation to support fetal development
Progesterone therapy to support early pregnancy
In addition to pharmacological management, detailed counselling was provided regarding her condition.

Patient Counselling

The patient was educated about uterus didelphys and its implications on pregnancy. She was informed about potential risks, including:
Preterm labor and premature birth
Fetal growth restriction
Malpresentation
Increased likelihood of emergency cesarean section
Need for close antenatal monitoring
The importance of regular follow-up and adherence to medical advice was emphasized.

Outcome and Follow-up

At the time of reporting, the patient is under regular antenatal follow-up. She is stable, compliant with medications, and undergoing periodic monitoring to assess fetal growth and pregnancy progression.

DISCUSSION

Uterus didelphys is a rare congenital Müllerian duct anomaly resulting from complete non-fusion of the paired Müllerian ducts during embryological development. This leads to the formation of two separate uterine cavities, each with its own cervix, and occasionally a longitudinal vaginal septum. Reported prevalence ranges between 0.1% and 0.5% in the general female population, making it an uncommon but clinically significant condition.
Several studies have demonstrated that women with uterus didelphys may have relatively preserved fertility compared to other Müllerian anomalies; however, they are at increased risk for

adverse obstetric outcomes. According to studies by Heinonen and colleagues, reproductive performance in such patients is often associated with complications such as preterm labor, malpresentation, and increased cesarean section rates. Similarly, Rackow and Arici reported that uterine anomalies, including uterus didelphys, are linked to higher incidences of fetal growth restriction and pregnancy loss, although many patients can still achieve successful pregnancies with appropriate care.

Early diagnosis plays a crucial role in optimizing pregnancy outcomes. Imaging modalities such as ultrasonography and magnetic resonance imaging (MRI) are commonly used to identify structural anomalies. In the present case, the diagnosis was made incidentally during a first trimester obstetric scan, which is consistent with previous reports where many cases remain undetected until pregnancy or evaluation for infertility.

Management of uterus didelphys during pregnancy is generally conservative, focusing on close antenatal surveillance rather than surgical correction. Progesterone supplementation, as given in this case, is often used to support early pregnancy, although its routine use depends on clinical judgment. Regular monitoring is essential to detect complications such as preterm labor or fetal growth abnormalities at an early stage.

Patient counselling is a critical component of management. Women should be informed about potential risks, including premature delivery, malpresentation, and the likelihood of operative delivery. However, it is equally important to reassure patients that favorable outcomes are achievable with proper antenatal care, as supported by multiple case series in the literature.

This case aligns with previously reported findings, demonstrating that uterus didelphys can be incidentally diagnosed in a primigravida with no prior reproductive complications. It underscores the importance of routine antenatal imaging and individualized patient management to ensure optimal maternal and fetal outcomes.

CONCLUSION

Uterus didelphys is a rare congenital anomaly that may remain undetected until pregnancy. Early diagnosis through routine antenatal imaging allows for appropriate counselling and careful monitoring to minimize adverse outcomes. With proper management, favorable maternal and fetal outcomes can be achieved.

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