CASE REPORT

An Accessory Uterine Cavity As A Cause of Pelvic Pain

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Abstract

Mullerian abnormality is a rare cause for pain abdomen and especially in multiparae who have dysmenorrhoea. It may interfere with quality of life. Surgical treatment if offered early may reduce suffering. We hereby report a case to increase the awareness regarding the mullerian abnormality as a cause of chronic pelvic pain in females.

Key words

Mullerian Abnormality, Accessory Horn

Introduction

Pelvic pain is a common gynaecological problem. It is a common complaint in young adolescents as well as adult females and encompasses dysmenorrhoea as well as chronic pain. It is often disabling and 50% of adolescents with severe pain have multiple school absences (1). The differential diagnosis of pelvic pain includes endometreosis, adenomyosis, congenital obstructive mullerian abnormalities, PID, ovarian cysts and other non gynaecological causes of pelvic pain. With obstructive congenital abnormalities, such as non communicating accessory uterine cavity, pelvic pain occurs because of accumulation of menstrual fluid within the reproductive tract (2). The diagnosis of mullerian abnormalities can be made via a sonography. Ultrasound is especially useful in identifying fluid filled cavities. However MRI is more specific for the evaluation of presence or absence of a functional endometrium (3). The gold standard for diagnosis of mullerian abnormalities is a diagnostic laparoscopy. Very rarely mullerian abnormalities (4) are reported as a reason for chronic pelvic pain in multiparous women (5). Pelvic pain is a common complaint in female population and hence mullerian anomalies should be a part of differential diagnosis. Awareness of this possibility will prevent or unnecessary delay in management. We report a rare case of pelvic pain caused by an obstructive mullerian anomaly with a normal uterine cavity and patent fallopian tubes.

Case

A thirty five year old gravida three para two abortion one was admitted with a history of right sided abdominal pain, which was worst during menses and used to subside after flow. Such history of dysmenorrhoea was present since the age of her menarche at 14 years and used to last 4-5 days. Even non steroidal anti-inflammatory drugs did not alleviate pain and pain was interfering with her family as well as official life. Development of her secondary sex characters were normal. Family history was not significant.

Pelvic examination revealed an anteverted, multiparous sized uterus and palpable mass on right side measuring 3-4 cm and no cleavage was found between uterus and mass. The mass was smooth and mobile with uterine movements. Ultrasound showed a 3 cms lesion in right lateral aspect of uterus and 5 cms to the right of a normal appearing endomentrial stripe. At laparoscopy a separate accessory horn of about 3-4 cms size was seen. Both tubes were seen entering separately from cornual regions therefore the diagnosis of accessory horn was made.

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When all her biochemical and haematological markers became normal a decision of laparotomy followed by hysterectomy was undertaken due to the severe cyclical pain and decreasing quality of life and no future requirement of pregnancies. A deliberate decision of laparotomy during the follicular (post menstrual phase) was taken. The hysterectomy with preservation of right ovary because the left ovary had small cystic areas posteriorly was done. The operative and post operative course was uneventful and uncomplicated. After the hysterectomy the specimen was cut open [Fig. 1] anteriorly and a 15-20 cc menstrual blood was seen in the main as well as the accessory horn. Probe examination revealed that there was no communication between two different mullerian derivatives. The diagnosis of a non communicating accessory horn with functional endometrium was made and was confirmed by the histopathological examination. The patients hospital course was uneventful and uncomplicated. Patient was followed for 1 year after the surgery and was free of pain and had better quality of life, no absence from duty and was looking after children well.

Discussion

Dysmenorrhoea, a common complaint may be disabling to cause a poor quality of her life. Primary dysmenorrhoea is commonly found in adolescent population, mullerian abnormalities may be the least diagnostic option.

It is rare for gynaecologists to have the diagnosis of mullerian abnormalities in mind while evaluating the chronic pelvic pain in the parous females. One may find cases of accessory horn with a nonfunctional endometrium but it is rare to find accessory horn with a functional endometrium.

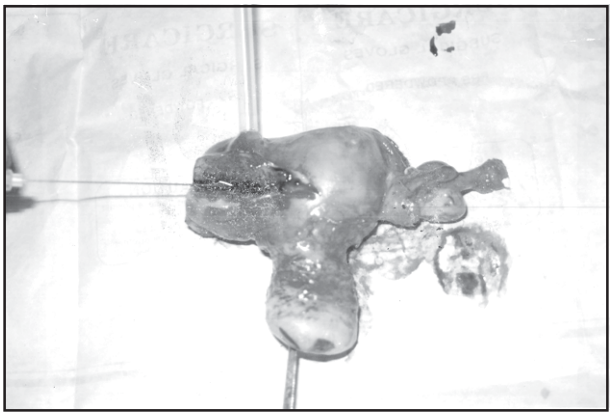

Fig-1 Uterus with Accessory Uterine Cavity

This case report presents a rare cause of pelvic pain; a non communicating accessory uterine horn with a functional endometrium (4). Based on Med line ovid literature search made in all available languages from 1966 to 2006, with search terms mullerian abnormality, " Pelvic pain, dysmenorrhoea, Management, Accessory uterine cavity,Uterus, abnormalities, there is only one other report of this type of case in the literature (5).

Awareness of this possibility will prevent delayed surgical treatment for better the quality of life.

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