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RUDIMENTARY HORN

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**Case Report****SUCCESSFUL ENDOSCOPIC MANAGEMENT OF NON-COMMUNICATING  
RUDIMENTARY HORN****Anshika Lekhi., Rahul Manchanda., Nidhi Jain and Sravani Chithra**

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**ARTICLE INFO****Article History:**Received 11<sup>th</sup> March, 2016Received in revised form 14<sup>th</sup> April, 2016Accepted 18<sup>th</sup> May, 2016Published online 28<sup>th</sup> June, 2016**Key Words:**Congenital, rudimentary horn,  
unicornuate uterus**ABSTRACT**

Unicornuate uterus with rudimentary horn is a müllerian duct malformation with incidence of 5-10% of all uterine malformations.

We discuss a case of 30 year old nulliparous patient, with chronic pelvic pain and dysmenorrhoea worsened over the past few months with future fertility concerns. USG showed a unicornuate uterus with a left sided uterine horn with an endometrial cavity; findings were confirmed by MRI. Patient underwent hysteroscopy with metroplasty &amp; laparoscopic resection of rudimentary horn. Hysteroscopic metroplasty helped to increase the size of the small cavity of the uterus and plan conception. She conceived after 6 months and delivered a healthy baby vaginally.

Excision of the rudimentary horn in most cases is similar to that of hysterectomy. Separation of the horn from the uterus is easy when there is merely a band of fibrous tissue between them. It becomes more complex when the horn is closely attached to the uterus. The gold standard for diagnosing Müllerian anomalies is hysteroscopy and laparoscopy.

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**INTRODUCTION**

Congenital malformations of the female genital tract are defined as deviations from normal anatomy resulting from embryological maldevelopment of the Müllerian or paramesonephric ducts. They represent a rather common benign condition with a prevalence of 4-7% [1,2,3].

Unicornuate uterus with rudimentary uterine horn results from arrested development of one of the two Müllerian ducts.

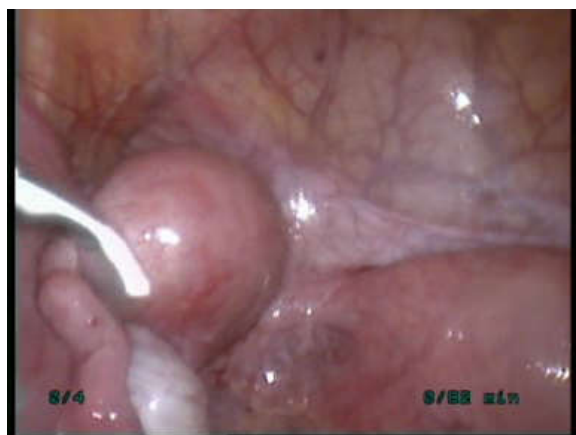


Figure 1

This uterine anomaly covers a wide range of anatomical variabilities and is divided into four subgroups according to the American Fertility Society classification of Müllerian anomalies: (IIa) rudimentary horn with cavity communicating to unicornuate uterus, (IIb) with cavity non-communicating, (IIc) with no cavity and (IId) with no horn (1988)[figure 1].

Type IIb is the most common and clinically significant type. It is also susceptible to many gynaecological and obstetric complications that may be avoided by the removal of the rudimentary horn and its tube (4). Nevertheless, this subgroup may encounter fine anatomical variations, particularly in the attachment of the rudimentary horn that may influence surgical treatment [5, 6].

**Case report**

40 year old nulliparous lady came with Complaints of chronic pelvic pain and severe dysmenorrhoea for the past few years, worsened over the past few months. She was also concerned about her future fertility options. USG showed a unicornuate uterus with a left sided uterine horn with an endometrial cavity and these findings were confirmed by MRI. Patient underwent Diagnostic and operative hysteroscopy with metroplasty [figure 2] and Diagnostic and operative laparoscopy with resection of the rudimentary horn and tube with fulguration of endometriotic lesions [figure 3].

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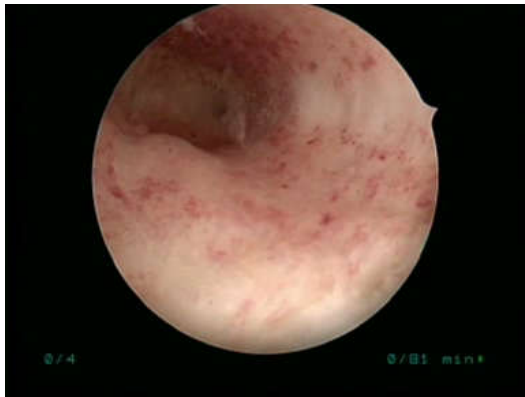


Figure 2

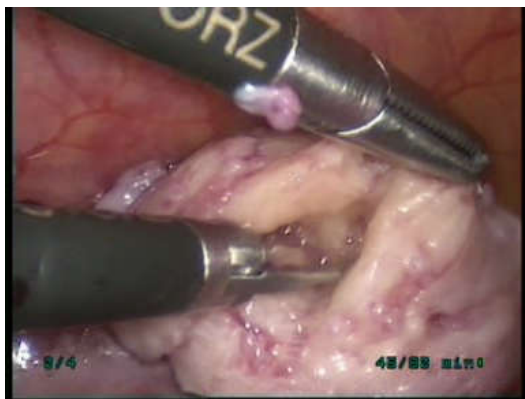


Figure 3

Finding on hysteroscopy was Unicornuate small uterine cavity whereas on laparoscopy it was Unicornuate uterus with left sided non communicating rudimentary horn with an endometrial cavity. B/l tubes were normal. B/l ovaries had endometriotic spots. Endometriotic spots on the utero-sacral ligaments were also seen. Histopathology of horn showed endometrium composed of tubular and straight glands lined by columnar epithelium. No mitosis was seen. Myometrium was unremarkable. Findings were correlated with rudimentary horn and weak proliferative endometrium. She conceived after 6 months and delivered a healthy baby vaginally.

## DISCUSSION

According to the American Fertility Society Classification, this type of rudimentary horn falls under Class II (b). However, the European Academy for Gynaecological Surgery (EAGS) has proposed a new classification system for Mullerian anomalies. This proposal has been also adopted as the scientific basis for the development of a new classification system by the common working group, meanwhile established by the European Society of Human Reproduction and Embryology (ESHRE) and European Society for Gynaecological Endoscopy (ESGE) under the working name CONUTA (CONgenital UTERine Anomalies).

The updated new proposal for the classification of uterine congenital anomalies is designed having mainly clinical orientation and based on a critical review of the available data on female genital tract malformations with their extensive interpretation.

Under this new classification system, the above case falls under Class IV (a)

Endometriosis is a commonly found associated pathology seen in women with functioning endometrium in the rudimentary horn and this can add to her symptoms. Hence excision of cavitated rudimentary horns is recommended to reduce the possibility of this occurring or reduce the severity of it.

Excision of the rudimentary horn in most cases is similar to that of hysterectomy. Separation of the horn from the uterus is easy when there is merely a band of fibrous tissue between them. It becomes more complex when the horn is closely attached to the uterus.

The excised rudimentary horn is ideally extracted intact either by a colpotomy incision or an extended lateral port so as to allow confirmation whether the horn is cavitated or not as morcellation may make it difficult to identify the endometrium. In our case, we have cut open the horn in situ (prior to in bag morcellation) and determined that the horn contained an endometrial cavity [figure 4].



Figure 4

Hysteroscopic metroplasty increased the size of the small cavity of the uterus and helped the patient for planning conception.

The gold standard for diagnosing Mullerian anomalies is hysteroscopy and laparoscopy.

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