

Original research article

Controversies in family planning: pregnancy termination in women with uterine anatomic abnormalities ☆, ☆, ☆, ★

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1. Case

A 35-year-old G3P2002 woman presented to our clinic for elective termination of her first trimester pregnancy. She had a history of one prior uncomplicated vaginal delivery at term, followed by an uncomplicated cesarean delivery at term for breech. Initial transvaginal ultrasound showed a single intrauterine pregnancy with a crown-rump length of 0.38 cm consistent with 6 weeks 1 day gestational age. The resident started the dilation but with some difficulty. The fellow took over and was able to adequately dilate and pass the 7-mm cannula but then noted no tissue return with the manual vacuum aspirator (MVA). The attending then performed transabdominal ultrasound guidance which showed that the cannula did not appear to be in the same cavity as the pregnancy; however, it did not appear extrauterine. We removed all instruments and performed a transvaginal ultrasound which showed two uterine cavities, with a thin endometrial stripe on the right and the intrauterine pregnancy on the left. At this point, the speculum was replaced, a second sterile prep was done and the attending attempted unsuccessfully to pass instruments into the left cavity under ultrasound guidance. We decided to proceed with a medication abortion using mifepristone and misoprostol. Two days later, the patient called the clinic reporting

that after taking the misoprostol she had cramping but no bleeding. Our team is planning to repeat the misoprostol. Any additional thoughts if this attempt is still not successful?

1.1. Response 1

I had a similar case a few years ago. She was already over 9 weeks gestational age after a failed abortion attempt at another clinic. I tried and could not get in the correct cavity under ultrasound guidance. We also tried mifepristone and misoprostol, which failed. She did have some spotting and we were able to identify a possible second external cervical os, but we were unable to pass even the smallest dilator. Our maternal fetal medicine colleagues helped with an injection of potassium chloride (KCl) at 11 weeks gestational age, and we continued with weeks of expectant management. The patient disappeared from care for a year. She denied ever passing any sizeable tissue and resumed normal menstrual cycles. A three-dimensional ultrasound found no retained tissue and suggests uterus didelphus. She is following up with reproductive endocrinologists for future pregnancy planning. I thus recommend expectant/ongoing medical management as long as the pregnancy is not progressing.

1.2. Response 2

Sometimes if I cannot get into a second cavity with my usual instruments, I can find my way in with a sound, which bends in more accommodating ways than dilators and cannulae. If I can get in with a sound, then I carefully thread an MVA cannula over the sound (retaining the bend required, sometimes even a U-like shape) and then I can get the cannula into the second cavity.

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1.3. Response 3

We saw a patient with a nonviable pregnancy at 9 weeks gestational age who had already had one dilation and curettage (D&C) attempt elsewhere after misoprostol did not work. She presented to us with bleeding. On ultrasound the pregnancy was still present. We took her to the operating room. We were unable to dilate the cervix even with ultrasound guidance. We used the diagnostic hysteroscope and easily found the correct cervical canal. We kept the hysteroscope in and used dilators under ultrasound guidance to complete the procedure.

1.4. Response 4

I would get a formal ultrasound in radiology. The worst possibility is that this is a rudimentary, noncommunicating horn with functional endometrium with sperm coming from the opposite side and fertilizing an ipsilaterally ovulated oocyte. If indeed it is a noncommunicating horn, then she will need a laparoscopic resection of the rudimentary horn. Magnetic resonance imaging (MRI) is another possibility but expensive, and radiologists can certainly do as well with a high-resolution ultrasound. If it is a communicating horn, then hysteroscopy and D&C would be a reasonable plan.

1.5. Response 5

We have had two similar cases. Both were in noncommunicating horns. After we were unable to access the pregnancy, we got an MRI. One patient opted for a gravid hysterectomy, and the other patient opted for a resection of the rudimentary horn. For that second patient we considered hysterotomy with tubal ligation on that side to prevent another pregnancy in that horn, but she was 14 weeks pregnant, and due to bleeding following hysterotomy, we resected the horn and repaired the uterus similarly to performing a myomectomy.

1.6. Response 6

We recently had a case at our institution where a woman presented with twins, one in each “horn” of what was thought to be a bicornuate uterus. The patient presented with one intrauterine fetal demise and severe pain, and she was found to have a uterine rupture in one horn. It turned out the demised twin was in the noncommunicating and now ruptured horn. She had a resection of the ruptured horn. The pregnancy (the other twin) continued in the other horn and was later found to have anomalies. Two weeks after the resection of the ruptured horn, she underwent an uncomplicated dilation and evacuation (D&E).

2. Case conclusion

The patient presented again to the clinic for follow up 1 day after the second misoprostol administration. This time she reported both bleeding and cramping. The bleeding was initially heavy but then slowed substantially. Transvaginal ultrasound was performed and showed two uterine cavities, each with a thin endometrial stripe and no evidence of ongoing

pregnancy. Given the successful medication abortion and the single cervix on physical exam, she was thought to have a septate, bicornuate or unicornuate uterus with a communicating horn. A Nexplanon was placed for contraception. The patient was referred for MRI to better elucidate her uterine and renal anatomy. She has not yet presented for this additional imaging. The patient has provided written consent for the publication of this case report.

3. Review

Surgical abortion is a safe procedure, and with the use of careful inspection of the aspirate, completion of the procedure can be confirmed [1–3]. If products of conception are not identified in the aspirate, steps must be taken to carefully assess the clinical technique and the patient’s anatomy. Several large case series have identified uterine anomalies as a risk factor for failed surgical abortion [4–6]. In one such series of more than 33,000 suction abortions at less than 12 weeks gestation, uterine anomaly was found have a relative risk of 90.6 for unrecognized failed abortion [4].

Approximately 0.5% of women in the general population and 0.2% of fertile women have congenital uterine anomalies [7]. In 1988 the American Fertility Society (AFS) proposed a classification system for Müllerian anomalies which is still widely used today [8]. Within this system, anomalies are divided into seven categories including (I) hypoplasia/agenesis, (II) unicornuate, (III) didelphus, (IV) bicornuate, (V) septate, (VI) arcuate and (VII) Diethylstilbestrol (DES) drug related. Of those women with uterine anomalies, 91% fall within a type that generally involves communication with a cervix (7% arcuate, 34% septate, 39% bicornuate and 11% didelphic) [7]. Only 5% of uterine anomalies are unicornuate [7]. Unicornuate anomalies are further broken down by anatomy into a classification system first proposed by Buttram and Gibbons in 1979 and later incorporated into the AFS system in 1988: (a) rudimentary horn with a cavity which communicates with the unicornuate uterus; (b) rudimentary horn with a cavity which does not communicate with the unicornuate uterus; (c) rudimentary horn with no cavity; and (d) unicornuate uterus without a rudimentary horn [8,9]. This wide range of anomalies presents a variety of challenges to the abortion provider. While there is a growing body of evidence regarding the obstetrical risks associated with the various uterine anomalies, little more than case reports are available to help guide management in the setting of pregnancy termination.

Determining the nature of the uterine anomaly can help in patient management. This can be accomplished with both careful physical exam and with the assistance of imaging techniques. A thorough pelvic exam can help to determine if there are one or two cervixes present, a vaginal septum and the size, shape and position of the uterus. The second cervix may be rudimentary or found laterally in the vaginal fornices. With appropriate tension from a tenaculum, such a cervix may be entered if necessary. While imaging is not always

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