Pregnancy after haematocolpos

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Fertility following haematocolpos has rarely been studied. The following case in which unilateral haematocolpos, haematotrachelos and haematometrium was released by making an incision between the two vaginas provided a formerly occluded horn with a 'normal' horn of uterus to act as a control. Both were exposed to the same patient's ovum and the same semen. It may be assumed, therefore, that implantation occurred in the more fertile horn.

Case report

On 29 May 1956, at 16 years of age the patient presented with a 2-week history of sharp, stabbing, intermittent lower abdominal pain radiating from the right to the left lower abdomen, recently more severe and accompanied by nausea and vomiting. There were no bowel or urinary symptoms. She had a regular 28-day menstrual cycle lasting 3–4 days. A firm, cystic mass which filled the whole pelvis was explored by laparotomy. On opening the peritoneal cavity, altered blood was seen on the right side. The cystic mass which filled the pelvis appeared to have both cornua of the uterus lying above it and both the Fallopian tubes leading from these appeared normal, though the right one was engorged. The ovaries were both normal. On vaginal examination the cystic mass bulged into the vagina anteriorly. Stale blood was aspirated from this and, on incision of the vagina, 30 fluid oz of stale blood drained. It could now be appreciated by using a uterine sound, that the cervix in the vault of the vagina communicated only with the left cornu of the uterus. Between this cavity (formerly occluded) and the right cornu there was a thin rim of cervix. A tube was temporarily stitched into the incision between the two vaginas. It was noted that the right kidney was absent and the left kidney hypertrophied.

Postoperatively an intravenous pyelogram confirmed absence of the right kidney with normal function on the left.

The patient was asked to attend again if marriage was envisaged.


Sadow, H.S. (1969) This question of lactic acidosis. Postgraduate Medical Journal, 47, Suppl. 34.
nal incision of the haematocolpos all pregnancies occurred in the formerly occluded (right) horn of the uterus in spite of the fact that sperm had to pass through the intravaginal ostium to reach the right cervix. Had the grossly distended semi-uterus been excised, leaving only the 'normal' horn as described for this condition (Miller, 1922; Wilson, 1925; Chureau, 1933; Embrey, 1950; Guillemin, 1950; Secher, 1954; Hill, 1958), the more fertile horn would have been lost. There is a high mortality for this operation (Brown & Brews, 1930).

Of forty similar cases in the literature (Quenu & Le Sourd, 1906; Purslow, 1922; Wilson, 1925; Simon, 1928; Brown & Brews, 1930; Gaggero & Crippa, 1931; Masson & Mueller, 1933; Bassett, 1933; Martindale, 1935; Guillemin & Guillemin, 1950; Embrey, 1950; Sechar, 1954; Semmens, 1956; Gibberd, 1957; Brews, 1957; Hill, 1958; Macdonald, 1960; Rouchy, 1963; Gottieb-Juntula, 1963), the majority have not been followed up to find out whether they proved fertile. Subsequent pregnancy is described in two cases only and never has the side which proved fertile been stated apart from a case of Allan & Cowan (1963) who thought the formerly occluded horn to be the fertile one at least once.

The greater fertility of the right horn may be due to the fact that one vagina and the contralateral horn of the uterus was better developed as described by Galloway (1937) and Jarcho (1946). On the other hand it may be that the slow gross dilatation of the cervix during the formation of a haematotrichelos itself might improve fertility. Substantiating this, a high fertility was found by Brews (1957) in treated simple haematocolpos. Ten out of eleven married over a year had conceived, the infertile one having had a pyosalpinx at the time of operation. Possibly prostaglandins absorbed from the dammed back menstruum play a part in improving the reproductive potential of the genital tract.

Opinion varies (Galloway, 1937; Taylor, 1943, Hunter, 1957) as to the desirability of Caesarean section in a bicornuate uterus but here the ostium between the two vaginas made abdominal delivery obligatory.

The high incidence of antepartum foetal distress and perinatal mortality in bicornuate uteri (Falls, 1956; Blair, 1960) is not reflected in this case apart from the meconium-stained liquor in the last two pregnancies.

The absent kidney is on the same side with the genital defect as noted by Shumacker (1938). This patient's urinary output remained adequate and her blood urea within normal limits throughout.

Contrary to Zabriskie's (1962) belief that each successive pregnancy in a bicornuate uterus is less prone to premature labour, this patient's only premature labour was her last. The breech presenta-

tion was typical of bicornuate uteri (Taylor, 1943; Jarcho, 1946; Hay, 1959).

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References


