THE 'INCOMPETENT CERVIX' ASSOCIATED WITH BICORNUATE UTERUS

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Full-term uneventful pregnancy has occurred in the congenitally deformed double uterus with the delivery of a normal healthy child. On the other hand, recurrent abortion, premature delivery, malpresentations and other abnormalities associated with labour, have been described.[1,2] It is estimated that of every 1,000 women, 2 have malformations severe enough to interfere with pregnancy.[1]

In a previous paper[3] I mentioned congenital defect as one of the causes of cervical incompetence. Such defect may lead to habitual abortion in the middle trimester of pregnancy.

With the exception of a recent case report,[4] no mention has been made of cervical incompetence associated with other congenital deformities of the uterus. The major deformities seem to attract all the attention, and possible cervical incompetence is overlooked. All the conditions favouring cervical incompetence are present in these cases: recurrent abortion and repeated curettage with possible damage to the cervix, and operative treatment, given in an attempt to correct a major abnormality, which may interfere with the normal function of the cervix. On X-ray examination these patients always seem to have a very wide cervical canal.

Jones *et al.*[5] reported a case where excision of a congenital cervical septum resulted in an incompetent and large patulous cervix. After operation the patient aborted at 2 months and at 4 months, whereas she had carried beyond the 20th week in all previous pregnancies.

The following are reports of 3 cases of marked bicornuate unicollis uterus which also shared all the diagnostic criteria of the incompetent cervical os.

CASE REPORTS

Case 1 — Mrs. L.D., Aged 30 Years

This patient was first seen in January 1959 complaining of infertility. She had had 3 abortions, each at 6 weeks, in 1955, 1956 and 1957. In 1957 the diagnosis of a bicornuate uterus was made and an operation to remove the septum was performed by another gynaecologist. No X-ray examination was made after operation, and since then she had been unable to conceive. General examination showed no abnormality. In view of the previous history a hysterosalpingogram was carried out, and this showed a markedly bicornuate uterus with a very wide cervical os. Apparently the septum had reformed. Soon after the hysterosalpingogram the patient conceived and the pregnancy continued without any trouble at all. The uterus, however, was always larger than expected for the period of gestation, and the possibility of a twin pregnancy was con-

sidered. At 29 weeks the membranes ruptured spontaneously, and immediately strong labour commenced reaching full dilatation within two hours. Twins were delivered. The first weighed 2 lb. 1½ oz. and it survived for only a few hours. The second twin was delivered by a breech extraction and weighed 2 lb. ½ oz.; it died on the third day. Subsequent examination showed that the cervical canal was abnormally wide.

Case 2 — Mrs. B.J., Aged 26 Years

She was first seen in November 1957 when she was threatening to abort. She was treated conservatively, but without success, and aborted at 18 weeks. Her house doctor performed a dilatation and curettage. She again conceived in February 1958, but throughout the early weeks of this pregnancy she had a blood-stained discharge, eventually aborting in May, at 12 weeks. When curettage was done it was found that she most probably had a bicornuate uterus. Six weeks later a hysterosalpingogram was performed and this confirmed the diagnosis. On hysterosalpingography it was also noted that a very wide cervical canal was present (Fig. 1). Since then she has again conceived and again aborted at 18 weeks.

Case 3 — Mrs. E.K.G., Aged 25, Gravida 3

This patient had aborted on 2 previous occasions, at 18 and 24 weeks' duration respectively. She was admitted to hospital with the diagnosis of incomplete abortion. According to her dates she was 18 weeks pregnant. However, the uterus was the size of a 24-week pregnancy on abdominal palpation. It was irregular and had a bulge on the right side which was thought to be a large fibroid. Under anaesthetic, while curettage was being performed, it was noticed that the uterus was of a bicornuate type, and this was confirmed radiologically at a later date. Gross widening of the cervical canal was noticed (Fig. 2).

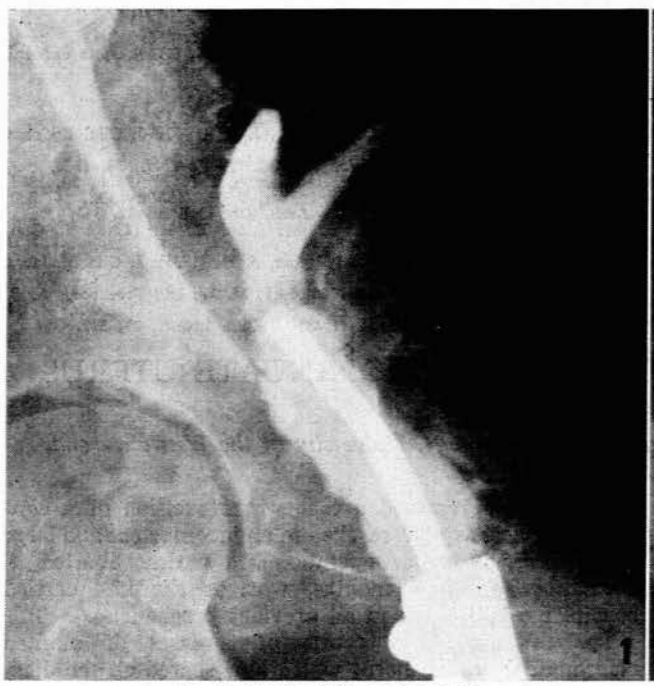

Fig. 1. Showing wide cervical canal.

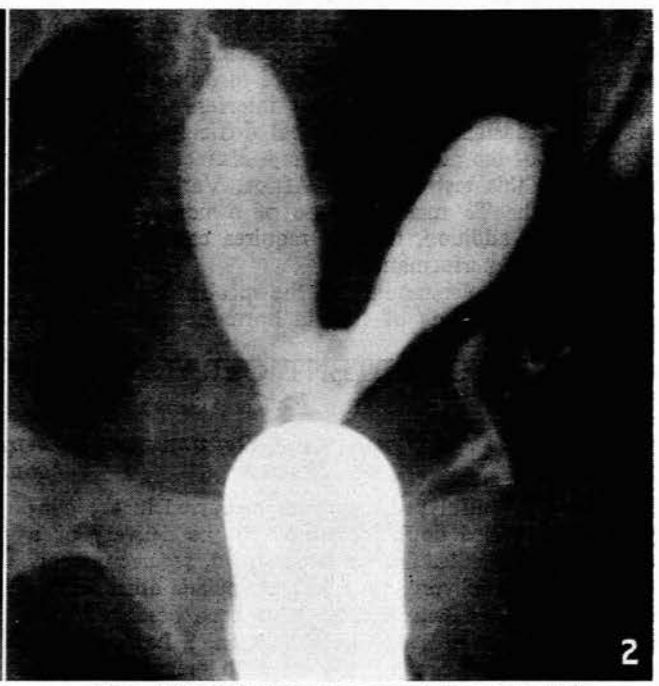

Fig. 2. Wide cervical canal with screw-type cannula visible.

DISCUSSION

Although the aetiology of the abortions and premature labour in these 3 cases could easily be accounted for by the gross uterine abnormalities, it can also be postulated that the abnormally wide cervical canal could have been a pertinent factor.

When the mechanism of the fusion of the Mullerian duct system in the production of uterine abnormalities is studied, it is not surprising that a very wide cervical canal is found with the bicornuate unicollis type of abnormality. On examining numerous plates of bicornuate uteri, this wide canal is invariably present, yet is never remarked upon. One must not be misled into thinking that a wide canal definitely means incompetency. On the other hand it is very suggestive evidence.

Before major operations are performed in these patients it would always be worth while to consider the possibility of an associated 'incompetent os'. Thus the minor procedure of cervical suture should first be contemplated. It may be performed in conjunction with the major procedure if this is deemed necessary.

SUMMARY

Three cases of bicornuate unicollis uterine abnormalities are described in association with repeated abortion.

These cases are reported in an attempt to focus attention on the fact that an 'incompetent cervix' might well be associated with this type of uterine abnormality.

Cervical suture should be considered before major plastic surgery is undertaken.

Thanks are due to the Photographic Unit, Department of Medicine, University of the Witwatersrand, for Fig. 2, and to Mr. M. Joffin for Fig. 1.

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