

# A Case of Locked Twins in Uterus Bicornis Unicollis

K. MARGOLIS

## SUMMARY

A case of a twin pregnancy in a uterus bicornis unicollis with a fetus in each horn presenting by the vertex, is described. Fetal distress supervened and the labour failed to progress because the head of the second twin locked between the neck and shoulder of the leading twin. Delivery, therefore, was by lower segment Caesarean section. The literature on this type of case is reviewed.

*S. Afr. Med. J.*, 48, 1461 (1974).

## HISTORY AND PHYSICAL FINDINGS

A Black primigravida aged 26 years was admitted to the Obstetric Unit in the third hour of labour. She had had no antenatal care in a symptomatically normal pregnancy. Her sisters were twins. On general and systematic examination her condition was normal and urinalysis revealed no abnormality.

On abdominal examination the size of the uterus corresponded with that of a term gestation. A twin pregnancy unassociated with polyhydramnios was diagnosed. Both fetuses were lying longitudinally and both presented by the vertex. The leading fetus was in the left occipitoposterior position and the second fetus was in the right occipitoposterior position. There was an obvious gap palpable between the breech of each fetus, and the mass of each fetus was estimated to be about 2500 g. Two distinct fetal hearts were heard—one on the left side and the other on the right side of the abdomen.

Vaginal examination showed the membranes to be intact, the cervix to be 50% effaced and 1,5 cm dilated, and the presenting vertex was high above the pelvic brim. The pelvic capacity was normal.

A clinical diagnosis of a nulliparous patient in early labour with a twin pregnancy and with a fetus in each horn of a uterus bicornis unicollis was confirmed by X-ray examination. There was no evidence of bony union of the fetuses.

## COURSE AND MANAGEMENT

The patient was admitted to the labour ward with the intention of allowing her to deliver vaginally. Obviously, special supervision to detect possible complications which might alter this programme was accorded.

During the first 6 hours, labour progressed favourably, the membranes ruptured, the cervix effaced fully and reached 4-cm dilatation. There was no further progress during the next 4 hours, however, for the cervical dilatation remained 4 cm and the level of the presenting vertex also remained unchanged. The liquor amnii became meconium-stained and the fetal heart rate slowed from 150 to 120 beats per minute. Consequently lower segment Caesarean section under general anaesthesia became necessary.

At Caesarean section the patient was found to have a uterus bicornis unicollis. The horns were fused just above the lower segment and each subtended its own Fallopian tube. The head of the second twin had locked between the head and the shoulder of the first twin. This arrested descent of the leading twin and the progress of labour.

Two healthy female infants, weighing 2160 and 2140 g respectively, were delivered, and the patient made an uneventful recovery.

## DISCUSSION

The reported incidence of congenital abnormalities of the uterus found in association with pregnancy varies tremendously. In a retrospective study an incidence of 3 per 1000 pregnancies (i.e. 0,3%) was found.<sup>1</sup> In a prospective study, in which routine manual exploration of the uterus was carried out immediately after delivery of the placenta,<sup>2</sup> the incidence was 33 per 1000 pregnancies (i.e. 3,3%).

Hay<sup>3</sup> stated that pregnant patients who have congenital abnormalities of the uterus show an increased incidence of antenatal and intrapartum complications. These result in an increase in maternal mortality and morbidity as well as increased perinatal mortality.

It has been stated<sup>4,5</sup> that vaginal delivery offers the best prognosis for the fetus and that Caesarean section should only be performed for obstetric indications—as was done in this case.

Jarcho,<sup>6</sup> in reviewing the literature, showed that the incidence of twinning is definitely increased in women with double uteri, and he quotes an incidence of twinning of 1 in 89 pregnancies in women with a single uterus against an incidence of 1 in 12 in women with double uteri.

Department of Obstetrics and Gynaecology, University of Natal and King Edward VIII Hospital, Durban

K. MARGOLIS, M.B. CH.B., DIP. MID. C.O.G. (S.A.), F.C.O.G. (S.A.), M.R.C.O.G.

Date received: 26 November 1973.

Tomkins<sup>7</sup> agreed with incidences of 1 in 80 and 1 in 20, respectively. This increased incidence is probably due to superfetation.

Although pregnancy in association with a congenital abnormality of the uterus is not uncommon, and the incidence of twinning has been found to be increased in patients with a double uterus, the finding of a bicornuate uterus with a fetus in each horn is very rare. Excluding the present case, only 18 cases have been reported. Miller, in reviewing the literature, found 7 recorded cases. Since then, others<sup>8-17</sup> have reported 1 case each.

The only other recorded case in the Republic of South Africa, and in addition the only other recorded case in which there was associated locking of the twins necessitating Caesarean section, was the case reported by Theron.<sup>17</sup>

## REFERENCES

1. Wilson, D. C. and Harris, G. H. (1961): *J. Obstet. Gynaec. Brit. Emp.*, **68**, 841.
2. Greiss, F. C. and Mauzy, C. H. (1961): *Amer. J. Obstet. Gynec.*, **82**, 330.
3. Hay, D. (1961): *J. Obstet. Gynaec. Brit. Emp.*, **68**, 361.
4. Baker, W. S., Roy, R. L., Bancroft, C. E., McGaughey, R., Norton-Dickman, F. and Tucker, G. W. (1953): *Amer. J. Obstet. Gynec.*, **66**, 580.
5. Fenton, A. N. and Singh, B. P. (1952): *Ibid.*, **63**, 744.
6. Jarcho, J. (1946): *Amer. J. Surg.*, **71**, 106.
7. Tomkins, P. (1962): *Surg. Clin. N. Amer.*, **42**, 1049.
8. Polak, J. O. (1923): *N.Y. St J. Med.*, **23**, 107.
9. Bainbridge, W. S. (1924): *Amer. J. Obstet. Gynec.*, **7**, 285.
10. Moncur, P. St. L. (1939): *Virginia Med. Mth.*, **66**, 593.
11. Corbet, P. R. (1941): *Irish J. Med. Sci.*, p. 501.
12. Williams, B. and Cummings, G. (1953): *J. Obstet. Gynaec. Brit. Emp.*, **60**, 319.
13. Brody, S. (1954): *Amer. Obstet. Gynec.*, **67**, 161.
14. Brown, D. B. (1956): *J. Obstet. Gynaec. Brit. Emp.*, **63**, 395.
15. Kennedy, N. (1959): *Brit. Med. J.*, **1**, 486.
16. Green, Q. L., Schanck, G. P. and Smith, J. R. (1961): *Amer. J. Obstet. Gynec.*, **82**, 340.
17. Theron, J. P. (1969): *J. Obstet. Gynaec. Brit. Cwlth*, **76**, 750.