

Laparoscopic Removal of a Rudimentary Uterine Horn in a Previously Hysterectomized Patient

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ABSTRACT

Background: The unicornuate uterine anomaly is often difficult to diagnose and usually low on the list of differential diagnoses for pelvic pain and dysmenorrhea. The authors present a case of a rudimentary uterine horn as a cause for continued pelvic pain and dysmenorrhea in a previously hysterectomized woman.

Case Report: A 43-year-old woman, gravida 1, para 1, presented for evaluation of right lower quadrant pain of several years' duration. Her past surgical history was significant for multiple prior laparoscopies and a vaginal hysterectomy. Radiographic studies revealed a mass in the right lower quadrant. Laparoscopy revealed a solid mass in the right pelvis that was diagnosed as a rudimentary uterine horn.

Conclusion: Uterine anomalies, although uncommon, should be thought of as part of the differential diagnosis for pelvic pain and dysmenorrhea. A thorough inspection of the pelvis should be performed at the time of any operative procedure for abdominal pain.

Key Words: Laparoscopy, Rudimentary uterine horn.

INTRODUCTION

The American Society for Reproductive Medicine has subclassified the unicornuate uterine anomaly into 4 subgroups¹: unicornuate uterus with communicating rudimentary horn,² noncommunicating horn with cavity present,³ noncommunicating horn without a cavity, and⁴ unicornuate uterus without a rudimentary horn.¹

The unicornuate uterus with rudimentary uterine horn is associated with symptoms, such as dysmenorrhea, hematometra, and endometriosis. The diagnosis of this condition is difficult, and the presenting symptoms can easily be falsely attributed to other disorders. Unfortunately, this condition is often an unexpected finding at the time of surgery for ectopic pregnancy or dysmenorrhea.

CASE REPORT

A 43-year-old gravida 1, para 1, woman presented for evaluation of right lower quadrant pain. This pain had been present for several years and was noted to be a constant dull ache with intermittent periods of intolerable sharp stabbing pain. She noted no modifying factors that worsened or relieved the pain. Her surgical history was significant for a Cesarean delivery for breech presentation with postpartum bilateral tubal ligation, transvaginal hysterectomy with tension-free vaginal tape placement, laparoscopic cholecystectomy, dilation and curettage (twice), inguinal hernia repair, and laparoscopic appendectomy.

The patient had undergone the transvaginal hysterectomy with ovarian conservation and a tension-free vaginal tape for dysmenorrhea and stress urinary incontinence 3 years before presentation. The operative report was reviewed and did not describe the appearance of the ovaries. The pathology report described a normal uterus. Of note, a preoperative pelvic ultrasound report described a right-sided uterine fibroid measuring 1.1 cm in average diameter.

After the hysterectomy, the patient continued to have a dull ache in the right lower quadrant. Two years after the hysterectomy, she had an acute exacerbation of her right lower quadrant pain. She was evaluated in the emergency department, and a computed tomographic (CT) scan of the abdomen revealed a mass in the right lower quadrant

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measuring 3.5x2.9 cm. This mass was seen overlying the cecum, and the study was interpreted as being suspicious for appendicitis. Laparoscopic appendectomy was performed. Surgical findings revealed a heterogeneous right adnexal mass. Intraoperative gynecologic consultation was obtained and a recommendation made for the patient to follow-up postoperatively with a gynecologic oncologist. The pathology report showed a normal appendix. She was subsequently lost to followup.

Physical examination findings included a right-sided tender, cystic, mobile adnexal mass. The mass was more readily palpable on rectovaginal examination than on vaginal examination. The mass was not fixed to either the vaginal cuff or the bladder. The mass did not fill the cul de sac and was definitely arising from the right side.

MRI of the pelvis showed a heterogeneous right-sided adnexal mass measuring 4.5 cm in its largest dimension. The mixed echogenicity made this suspicious for a teratoma. Her CA-125 level was 11.3 U/mL.

The decision was made to perform diagnostic laparoscopy. Operative findings included absence of the uterus. The left ovary and distal fallopian tube were normal. There was a solid mass in the right pelvis. Attached to the mass was a normal-appearing fallopian tube. The right ovary was normal size with multiple, small simple cysts. The ureter was followed along its course both proximal and distal to the mass. The diagnosis of rudimentary uterine horn was made. **Figure 1** is a photo of the mass taken through the laparoscope.

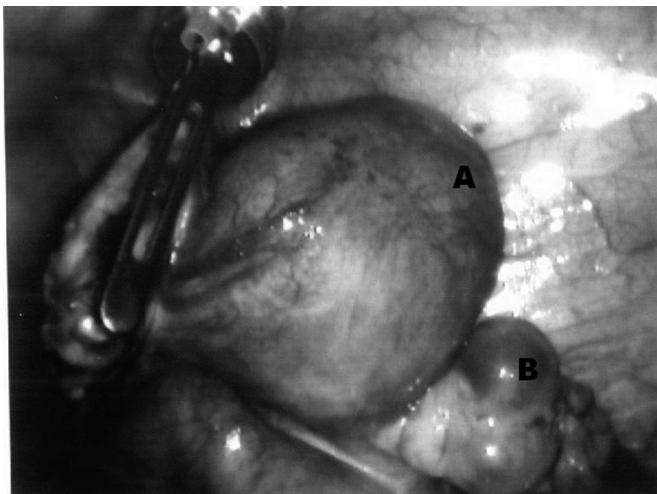


Figure 1. Laparoscopic picture of rudimentary uterine horn (A). Right ovary (B).

The rudimentary uterine horn, fallopian tube, and right ovary were removed laparoscopically using bipolar energy and sharp dissection. The rudimentary uterine horn was opened and inspected off of the surgical field and was of the cavitory noncommunicating type.

Pathologic evaluation of the surgical specimen showed a rudimentary uterine horn with proliferative endometrium and adenomyosis, normal ovary, and endometriosis of the wall of the fallopian tube.

The patient was discharged home on the day of the procedure. She had an uncomplicated postoperative course and 2 months after the procedure continued to be free of pain.

DISCUSSION

Uterine anomalies occur infrequently and are therefore not usually thought of in the differential diagnosis in patients with pelvic pain, particularly in a patient who had previously undergone hysterectomy. Management of a rudimentary uterine horn consists of laparoscopic removal of the horn and ipsilateral fallopian tube to relieve dysmenorrhea, to prevent endometriosis from retrograde menstruation, and to prevent future rudimentary horn pregnancy.²

This case illustrates the need for a thoughtful and thorough evaluation of the pelvic organs at the time of laparoscopy or other pelvic operative procedures. Uterine anomalies must be considered as a potential source of pelvic pain, especially when the pain occurs in a cyclic fashion.

References:

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