Abstract:
Mullerian Duct Anomalies occur in 2-3% of all women. Congenital anomalies of female genital tract results from mullerian duct anomalies and abnormalities of cloaca and urogenital sinus. Associated urinary tract anomalies are common due to the close developmental relationship between the two. Here we present a case of female hypospadias and mullerian duct anomaly. A 24 year old G3P2L0 with previous two caesarean section with bicornuate uterus with pregnancy in left horn was admitted and she was managed by elective repeat caesarean section.

Keyword: Female Hypospadias, Bicornuate uterus

Introduction:
Abnormal fusion of the mullerian ducts during embryological life results in a variety of congenital uterine malformations, the etiology of such abnormalities remains unknown. Mullerian duct anomalies occur in 0.1 to 3% of women, bicornuate uteri are thought to represent approximately 10% of mullerian duct anomalies. 15 to 25% of women of such congenital uterine anomalies have problems with fertility and reproduction such as miscarriage, preterm labour, preterm premature rupture of membranes, malpresentation and so on. Having a pregnancy with a bicornuate uterus is rare especially if it is associated with hypospadias. In a female, external meatus is normally located between clitoris and vagina. Female Hypospadias is a developmental anomaly in which urethra opens into vagina. In females, hypospadias is much less common than in males. It appears once in every 500,000 female births.

Case summary:
A 24 year old Gravida3, Para2, Live0, gestational age of 38 weeks 4 days with previous two caesarean sections with bicornuate uterus and pregnancy in the left horn with preeclampsia was admitted for safe confinement. Her menstrual history was regular 3/30 cycles. She was married since 3 years and it was a non consanguineous marriage. Obstetric history- her first pregnancy became an IUD at 28 weeks which
was delivered by hysterotomy, the indication being vaginal stenosis. She gives history of pregnancy induced hypertension during that pregnancy. There was difficulty in catheterisation for which urologist was called over and urethra was found to be inside the vagina. Her second pregnancy - delivered by caesarean section, an alive boy baby which died soon after birth due to congenital diaphragmatic hernia. Third pregnancy is her present pregnancy. Past history - no difficulty in micturition since childhood. On examination: General condition was fair Pulse rate-82/min Blood pressure was 120/80 mmhg in right upper limb in sitting posture. Abdominal examination - fundal height corresponds to term gestation with a single live fetus in breech presentation with good fetal heart rate. Presenting part was mobile. Local examination - external urethral meatus not visible. Vaginal orifice was narrow with a blind ending pouch with ? probable urethral orifice in the anterior vaginal wall. Pre operative investigations were within normal limits. She was posted for elective repeat caesarean section.

Per operative findings:
Abdomen and perineum draped with patient in lithotomy position, digital palpation of vaginal dimple done. Blind ending pouch with fibrosis felt anteriorly with urethral orifice felt in anterior vaginal wall. Laparotomy proceeded by midline vertical incision and LSCS done in usual way and an alive boy baby of 2.8 kg was delivered as breech. Bladder was distended unusually. Urologist was called over. Vescicotomy done and internal meatus was made out and foley’s catheter 16 french was introduced through the internal meatus and brought out through the vaginal orifice. The external urethral meatus was in the anterior vaginal wall. Bladder was closed over 28 french malecot’s catheter in two layers. Prevesical drain kept and abdomen closed after securing perfect hemostasis. Post operative period was uneventful. Suprapubic catheter removed after three weeks and patient was sent back home with the urologist advice of urethral reconstructive surgery after three months.

Discussion:
The mullerian ducts or paramesonephric ducts are paired ducts of mesodermal in origin in the embryo. They run laterally down the side of the urogenital ridge and terminate at the mullerian eminences in the primitive urogenital sinus. In the female they will develop to form fallopian tubes, uterus and the upper portion of vagina. In males, they regress. It is possible to detect bicornuate uterus using gynecologic sonography, specifically sonohysterography and MRI. However as there is no indication to do operative procedures in an asymptomatic women, the presence of bicornuate uterus may not be detected until pregnancy.
women with congenital uterine malformations usually have a higher incidence of infertility and complications with poorer obstetric outcome during pregnancy and delivery. Female hypospadias is an anomaly of female urogenital apparatus, a defect of posterior wall of urethra and anterior vaginal wall in which the external urethral meatus opens into the cavity of vagina. This case is being presented for its rarity of female hypospadias and associated bicornuate uterus.

References: