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# BREECH PRESENTATION IN A PRIMIGRAVIDA WITH BICORNUATE UTERUS, PLACENTA ACCRETA.

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***Abstract***

A 20-year-old primigravida at 38 weeks gestation presented in active labor with a breech presentation. Clinical evaluation suggested a bicornuate uterus with a noncommunicating rudimentary horn. Emergency cesarean section was performed, delivering a breech infant. Intraoperatively, placenta accreta was noted with partial adherence to the uterine wall, complicating placental removal. Most placental tissue was manually removed, with some retained. There was no active postpartum bleeding. The surgical site was secured, and the patient was monitored postoperatively. Ultrasound was used to assess retained products, and regular follow-up was arranged to monitor for complications. This case highlights the importance of early antenatal diagnosis of müllerian anomalies and placental disorders. Bicornuate uterus with a rudimentary horn can pose significant peripartum risks, including uterine rupture or abnormal placentation. Placenta accreta further complicates delivery and requires careful management to avoid hemorrhage. Timely surgical intervention, accurate intraoperative assessment, and close postoperative monitoring are essential in managing uterine anomalies and placental complications. Early diagnosis can improve maternal and fetal outcomes in such high-risk pregnancies.

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## INTRODUCTION

Congenital uterine abnormalities arise from the Congenital uterine anomalies result from defective fusion, canalization, or resorption of the müllerian ducts during embryogenesis, with a reported prevalence of 0.1–3.5% in the general population and up to 13% in women with recurrent pregnancy loss or infertility [1,2]. A bicornuate uterus, classified as a Class IV müllerian anomaly by the American Society for Reproductive Medicine (ASRM), arises due to incomplete fusion of the müllerian ducts, leading to a uterus with two endometrial cavities and a shared cervix [3]. This anomaly can go undetected until complications arise in pregnancy, including recurrent miscarriage, preterm labor, malpresentation (e.g., breech), and increased risk of cesarean delivery [4,5]. In some cases, a rudimentary horn may be present, which may or may not communicate with the main uterine cavity. Pregnancies within a noncommunicating rudimentary horn are rare but pose a high risk of uterine rupture due to limited distensibility [6]. In addition to structural anomalies, complications such as **placenta accreta**—abnormal adherence of the placenta to the myometrium—may coexist, especially when uterine scarring or abnormal uterine architecture is present. Placenta accreta is associated with life-threatening postpartum hemorrhage and

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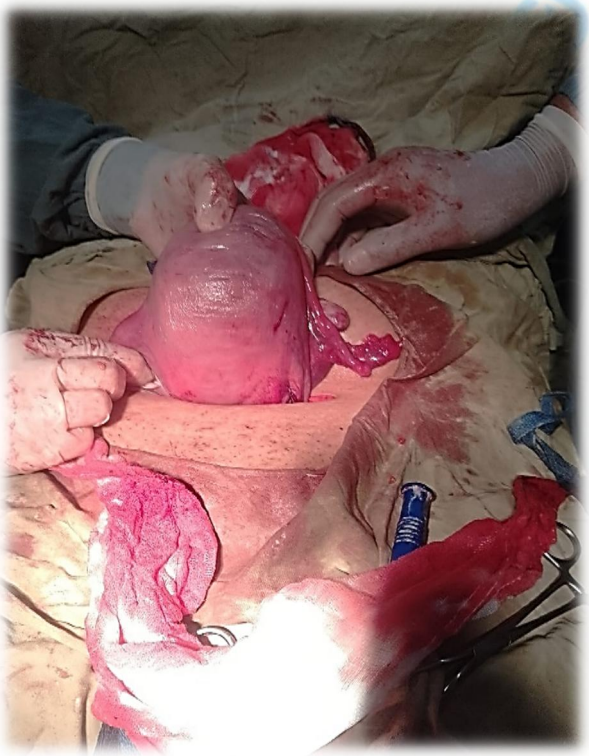
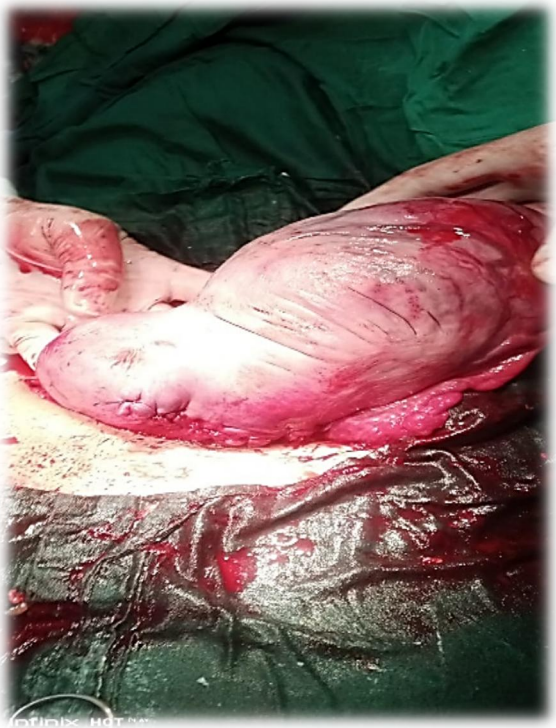
may require prompt surgical intervention [7]. This case highlights the clinical complexity and emergent management required in a primigravida with a bicornuate uterus, breech presentation, and placenta accreta, underscoring the need for early prenatal identification and multidisciplinary planning.

## METHODOLOGY

A 20-year-old first-time pregnant woman (Primigravida) came to the hospital at 38 weeks of pregnancy in an emergency condition with a breech presentation, where the baby was positioned feet-first. No prior histopathological testing had been conducted. Upon clinical evaluation, doctors suspected a congenital uterine abnormality, specifically a failure in the fusion of the müllerian ducts. This meant that one side of the uterus did not form properly, resulting in a rudimentary horn—a small, underdeveloped part of the uterus—to which the fallopian tube and ovary were abnormally attached. This condition is dangerous because if a pregnancy occurs in the rudimentary horn, it may rupture and lead to massive internal bleeding, creating a life-threatening obstetric emergency. To identify such abnormalities before complications, arise, recommended diagnostic tools include a Hysterosalpingogram (HSG), MRI, and laparoscopy. Due to the emergency nature of the case, a cesarean section (C-section) was carried out to deliver the baby, who was successfully delivered in a breech position. However, complications followed during the removal of the placenta, which could not be extracted using standard Controlled Cord Traction (CCT) techniques. It was then identified as a case of Placenta Accreta, a condition where the placenta is abnormally attached to the uterine wall. Most of the placental tissue was removed manually, although some tissue remained inside the uterus. Fortunately, there was no active bleeding observed at the end of the procedure, and the surgical site was secured. The patient was carefully monitored, informed about her condition, and underwent an ultrasound to assess the retained tissue. She was advised to return for follow-up appointments to ensure complete recovery. This case demonstrates the critical importance of early diagnosis and management of rare uterine anomalies and placental disorders, highlighting how timely surgical intervention and thorough post-operative care can stabilize the patient and reduce future risks.





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*A: Surgical Procedure Image. B: Bicornuate Uterus) and Reproductive Complications Images Source: Timergara Teaching Hospital Gyne/Obs Department*

The images from Timergara Teaching Hospital's Gynecology/Obstetrics Department illustrate a surgical procedure (Image A) and a bicornuate uterus with its reproductive complications (Image B). The surgical image likely depicts a diagnostic during the ceasearin section to diagnose or repair a bicornuate uterus—a congenital anomaly where the uterus has two horns due to incomplete fusion of the Müllerian ducts. This condition can cause significant reproductive challenges including recurrent miscarriages, preterm labor, malpresentation, intrauterine growth restriction, and infertility. Surgical correction aims to create a unified uterine cavity to improve pregnancy outcomes, often followed by hormonal therapy and a recovery period before conception. The hospital's gyne/obs department likely offers comprehensive care involving diagnosis, surgery, and high-risk pregnancy management to support affected women.

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**Table: compared our Case with other reported cases in district dir lower.**

| Age | Presentation | Diagnosis | Management | Outcome | Duration of Symptoms | Surgical Procedure Type | Postoperative Complications | Followup Care Required | Psychological Impact | Medical History | Social History | 2/7/2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 30 | Recurrent miscarriage | Hysteroscopy and laparoscopy | Surgical correction | Uneventful recovery | 4 months | Exploratory surgery | Mild cramping | None | Moderate stress | First pregnancy | Married, 2 children | 2/6/2022 |
| 29 | Preterm labour | Hysteroscopy | Cesarean section | Relief from pain | 1 month | Laparotomy | Postpartum hemorrhage | 1-year Followup | Moderate stress | History of fibroids | Married | 8/1/2024 |
| 26 | Ovarian cysts | Hysteroscopy | Medical management | Symptom relief | 10 months | Hysteroscopic surgery | Postpartum hemorrhage | None | Anxiety | First pregnancy | No children | 5/5/2023 |
| 34 | Pelvic pain | ULTRASOUND and laparoscopy | Cesarean section | Symptom relief | 1 month | Laparotomy | Mild cramping | 6-month Followup | Anxiety | History of fibroids | Married, 2 children | 7/2/2022 |
| 28 | Dysmenorrhea and pelvic pain | Endometrial biopsy | Surgical correction | Symptom relief | 6 months | Cesarean section | Minimal bleeding | 6-month Followup | Emotional distress | History of endometriosis | Married, 2 children | 4/9/2023 |
| 30 | Abnormal uterine bleeding | Endometrial biopsy | Surgical exploration and closure | Symptom relief | 1 month | Exploratory surgery | Minimal bleeding | None | Anxiety | First pregnancy | Single | 2/7/2024 |
| 34 | Infertility | Hysteroscopy | Cesarean section | Successful pregnancy | 6 months | Hysteroscopic surgery | Mild cramping | 6-month Followup | Emotional distress | History of endometriosis | Married | 2/6/2022 |
| 34 | Preterm labour | Intraoperative discovery | Surgical excision of fibroids | Symptom relief | 1 month | Laparotomy | Minimal bleeding | 6-month Followup | No psychological impact | History of fibroids | Married, 2 children | 8/1/2024 |
| 26 | Pelvic pain | Hysteroscopy and laparoscopy | Surgical exploration and closure | Successful pregnancy | 6 months | Laparotomy | Mild cramping | 1-year Followup | Emotional distress | History of fibroids | No children | 5/5/2023 |
| 27 | Infertility | Hysteroscopy | Surgical exploration and closure | Successful pregnancy | 3 months | Hysteroscopic surgery | None | 1-year Followup | Anxiety | History of endometriosis | Married, 2 children | 7/2/2022 |
| 30 | Ovarian cysts | Hysteroscopy and laparoscopy | Hysteroscopic resection | Successful pregnancy | 4 months | Cesarean section | Postpartum hemorrhage | None | No psychological impact | First pregnancy | No children | 4/9/2023 |
| 3 | Abnormal | Intraoperative | Hysteroscopic | Successful | 10 months | Laparotomy | Minimal | 6-month | Anxiety | No chronic | Single | 2/7/2024 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | uterine bleeding | discovery | resection | pregnancy | | | bleeding | Followup | | conditions | | |
| 29 | Preterm labour | US and ULTRASOUND | Cesarean section | Preterm delivery | 8 months | Cesarean section | Postpartum hemorrhage | None | Moderate stress | History of fibroids | No children | 2/6/2022 |
| 34 | Abnormal uterine bleeding | Intraoperative discovery | Medical management | Symptom relief | 6 months | Laparotomy | Postpartum hemorrhage | 1-year Followup | No psychological impact | History of fibroids | Married | 8/1/2024 |
| 32 | Recurrent pregnancy loss | Hysteroscopy and laparoscopy | Hysteroscopic resection | Relief from pain | 8 months | Cesarean section | Mild cramping | 1-year Followup | No psychological impact | No chronic conditions | Married, 2 children | 5/5/2023 |
| 32 | Recurrent pregnancy loss | Hysteroscopy | Surgical unification | Successful pregnancy | 5 months | Cesarean section | Mild cramping | 1-year Followup | Emotional distress | History of fibroids | Single | 7/2/2022 |

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## DISCUSSION

This case of a 20-year-old primigravida with an emergency breech presentation and undiagnosed uterine anomaly highlights the significance of early detection and intervention in obstetric complications. The diagnosis of a congenital uterine abnormality, specifically a rudimentary horn, underscores the importance of understanding Müllerian duct anomalies (MDAs) in the context of obstetric care. In this case, the failure of Müllerian duct fusion led to the development of a rudimentary horn, which was connected to the ovary and fallopian tube. If such anomalies are not identified before or during pregnancy, they can pose serious risks to maternal and fetal health, such as uterine rupture, hemorrhage, or complications during labor and delivery [8]. Müllerian Duct Anomalies (MDAs), such as the bicornuate uterus and rudimentary horn, are congenital conditions caused by abnormal development of the Müllerian ducts during embryogenesis. These anomalies are often diagnosed through imaging techniques, including Hysterosalpingogram (HSG) and laparoscopy, which help assess uterine morphology [9]. The rudimentary horn in this patient, which is often associated with a risk of ectopic pregnancy or rupture, can be life-threatening if undiagnosed. Pregnancy in a rudimentary horn, known as a horn pregnancy, may result in rupture, leading to catastrophic hemorrhage, which necessitates prompt diagnosis and surgical intervention [10]. Placenta accreta, which was identified in this case, further complicates the delivery process. Placenta accreta occurs when the placenta implants too deeply into the uterine wall, preventing normal detachment post-delivery and causing difficulties during placental removal. This condition increases the risk of severe postpartum hemorrhage and may necessitate hysterectomy in extreme cases [11]. In this patient, most of the placental tissue was manually removed, though some tissue remained, making follow-up essential to ensure complete placental removal and to monitor for potential complications like infection or retained placenta. The management of placenta accreta typically involves a multidisciplinary approach, including obstetricians, anesthesiologists, and blood transfusion services. The early detection and management of this condition are crucial to minimize maternal morbidity and mortality [11]. In our case, the patient's timely cesarean section, followed by careful manual removal of the placenta, was successful in preventing severe complications such as excessive hemorrhage. Furthermore, the patient's postoperative management underscores the importance of comprehensive care after such complex deliveries. The use of ultrasound to assess retained placental tissue is essential in confirming the completeness of placental removal and ensuring that no complications arise. Postoperative monitoring is crucial, particularly for patients with uterine anomalies, as these patients are at a higher risk for future reproductive complications, including preterm labor, uterine rupture, and infertility [10]. Regular follow-up appointments are necessary to evaluate uterine healing and fertility potential

## Conclusion

This case highlights the critical importance of early diagnosis and management of congenital uterine anomalies and placental disorders in obstetric care. The presence of a rudimentary horn, resulting from an incomplete fusion of the Müllerian ducts, poses significant risks to both maternal and fetal health, especially when it remains undiagnosed. Additionally, placenta accreta, a condition in which the placenta abnormally attaches to the uterine wall, further complicates delivery and poses a risk for severe hemorrhage. Timely surgical intervention, such as the emergency cesarean section in this case, was crucial in ensuring the safe delivery of the baby and in managing the complications that arose during placental removal. The manual removal of most of the placental tissue, despite some retained tissue, was successful in preventing severe bleeding, and the patient was carefully monitored postoperatively. This case underscores the necessity of early imaging and careful monitoring during pregnancy to detect uterine anomalies and placental disorders, thus preventing life-threatening complications. Furthermore, it highlights the need for thorough postoperative follow-up, including ultrasound evaluation, to ensure complete placental removal and to monitor for any future reproductive issues. Early recognition, multidisciplinary care, and appropriate surgical management significantly

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contribute to improving maternal outcomes and minimizing the risks associated with these complex obstetric conditions.

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