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Septate Uterus and Full-Term Pregnancy in the Gynecology Department of the Mali Hospital in Bamako

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Summary: **Case Report**

Septate uterus is the most common uterine malformation, accounting for 30 to 50% of cases. Our study concerns a case of **corporeal septate uterus,** discovered incidentally during surgery during a scheduled cesarean section whose indication was transverse presentation of the fetus. The interest of our study focused on the possibility of carrying a pregnancy to term in the case of certain uterine malformations (septate uterus) despite numerous obstetric complications that can cause these uterine malformations.

Keywords: Septate uterus, fertility, dystocic presentations, cesarean sections.

INTRODUCTION

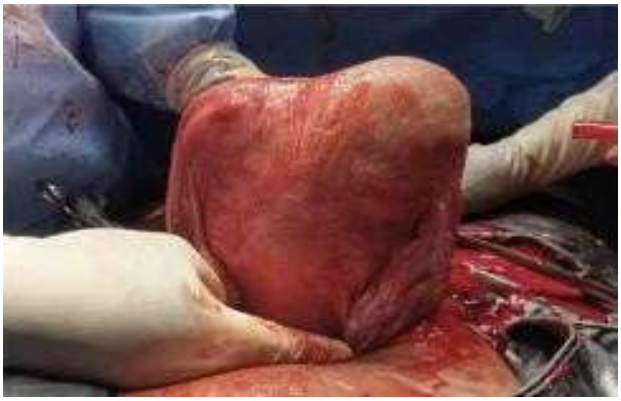
A septate uterus is a congenital uterine malformation characterized by the presence of a septum that separates the uterine cavity in two. This septum can be total or only partial. We speak of cervical, corporeal, subtotal or total septum [2]. **The uterus is cervical septate when** the septum is located at the level of the cervix (the cervix is the lower part of the uterus). It is **corporeal septate** when the septum only divides the body of the uterus (the body is the main part of the uterus). We speak of **a subtotal septate uterus** when the septum is present from the fundus of the uterus to the isthmus (the fundus is the upper part of the uterus and the isthmus corresponds to the part located just before the cervix) at the end. **The uterus is total septate** when the septum separates the uterus from the fundus to the cervix and sometimes even to the vagina. In this case, we speak of a complete urethro-vaginal septum [2]. The fetus develops in the uterus. When the shape of the uterus is abnormal, such as a septate uterus, proper fetal development can be more difficult. The fetus can quickly run out of space, and contractions can start prematurely. The risk of miscarriage is then higher, as is premature delivery or breech delivery when the baby has not been able to turn. However, pregnancy is still possible, but it requires very close monitoring. The doctor may also

prescribe continuing the pregnancy on bed rest, lying down to avoid premature delivery. A cerclage may also be indicated in the case of incompetent cervix (an abnormally large opening of the cervix). Cerclage is a surgical procedure that tightens the cervix by tying a non-absorbable thread around the cervix [2]. Pregnancies with a septate uterus are at risk of secondary obstetric complications due to a reduced uterine cavity and less efficient musculature in a septate uterus. The aim of our study was to show that despite these obstetric complications, certain uterine malformations such as septate uterican allow the development of a full-term pregnancy.

PATIENT AND OBSERVATION

We report the case of a 29-year-old female teacher, second act, second parity with a live G2P1V1 child, whose first delivery was premature at 34 weeks of amenorrhea. Her rhesus blood group is A positive. She was seen at our outpatient clinics for pregnancy monitoring. The prenatal follow- up laboratory assessment was unremarkable. The ultrasound performed at the same time 09/12/2024 concluded a progressive singleton intrauterine pregnancy at 37 weeks of amenorrhea with a transverse fetus without placental abnormality without further details regarding the structure of the uterus.

After a preoperative assessment and an anesthetic consultation, we scheduled a prophylactic cesarean section, which was performed on 12/12/2024, which allowed us to deliver a live female infant weighing 3090g. Apgar 9/10 at the first minute and 10/10 at the 5th minute. During surgery, we discovered a uterus with a transverse major axis with almost a non-existent lower segment that was very poorly amplified. During uterine revision, we noted an appearance of uterine malformation corresponding to a subtotal septate uterus, a septum affecting the uterine fundus. We did not have any other therapeutic approach to this malformation. The rest of the procedure was unremarkable.



DISCUSSION

Although a septate uterus is rare, it is one of the most common uterine anomalies, accounting for approximately 35–90% of congenital uterine irregularities [8].

GYNECOLOGICAL AND OBSTETRIC HISTORY

Soukaïna Laaraj *et al*., [3] reported the case of a 23-year-old patient with a second nulliparous procedure (2 early spontaneous abortions not curetted).

On the other hand, Osman Ali *et al*., [1] reported the clinical case of a septate uterus in a 21-year- old primigravida with no particular history. Our case involved a second procedure with a history of premature delivery. In both cases reported, as in our case.

The pregnancy was carried to term ÿ 37 weeks. Premature delivery was found in the obstetric history of our patient and Soukaïna Laaraj *et al*., [3] had found 2 early spontaneous abortions. In all three cases, transverse dystocic presentation was found. This illustrates with the data in the literature the complications linked to these uterine malformations, specifically septate uteri.

DELIVERY

Cesarean delivery is the most widely described method of delivery in the literature, given the vicious dystocic presentations that these septate uteri can cause. Our approach, as well as that of Soukaïna Laaraj *et al*., [3] and Osman Ali *et al*., [1] was to perform cesarean section for a favorable birth outcome.

OUTCOME OF PREGNANCY

Soukaïna Laaraj *et al*., [3] the pregnancy was carried to 36 weeks, Osman Ali *et al*., [1] it carried to 39 weeks. Our case reported the pregnancy was carried to 38 weeks.

Thus, despite the increased risks of repeated miscarriages and premature birth, septate uteri sometimes allow the development of full-term pregnancies [1, 3].

CONCLUSION

Uterine malformations, although responsible for many obstetric complications, can sometimes result in a live birth at term in the event of pregnancy.

Conflitcts of Interest: The authors declare no conflict of interest.

Authors' Contributions

The study was initiated by MARIKO S. and TRAORE A. The manuscript was written by MARIKO S. All authors read and approved the final version of the manuscript.

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