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Case Presentation

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Breech Presentation in a Unicornuate Uterus

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Abstract

Background: Congenital uterine anomalies are rare malformations resulting from abnormal Müllerian duct development. The unicornuate uterus is an uncommon subtype associated with adverse obstetric outcomes, particularly fetal malpresentation, Intrauterine Growth Restriction (IUGR), and increased cesarean delivery rates.

Case report: We report the case of a 28-year-old primigravida with an unmonitored pregnancy who presented at 40 weeks of gestation in spontaneous labor. On admission, she was in the active phase of labor with an incomplete breech presentation. Obstetric ultrasound confirmed a singleton pregnancy with suspected IUGR and breech presentation. Initial fetal heart rate monitoring was reassuring; however, intrapartum fetal distress occurred, characterized by decelerations, requiring emergency cesarean section. A female neonate was delivered with a birth weight of 2400 g and an Apgar score of 10/10 at 1 and 5 minutes. Intraoperative examination incidentally revealed a unicornuate uterus.

Conclusion: This case highlights the association between unicornuate uterus, breech presentation, and intrapartum fetal distress. The diagnosis was made incidentally during cesarean delivery due to lack of antenatal follow-up. This emphasizes the importance of considering Müllerian anomalies in cases of fetal malpresentation and the need for close intrapartum surveillance to ensure timely obstetric intervention and favorable maternal-fetal outcomes.

Keywords: Breech presentation; Unicornuateuterus; Caesarean section

Introduction

Congenital uterine anomalies result from abnormal development of the Müllerian ducts during embryogenesis, involving disruptions in their formation, fusion, or resorption. These structural malformations are observed in 1–10% of the unselected general population, in 2–8% of women

with infertility, and in 5–30% of those with a history of recurrent miscarriages [1]. Maternal uterine anomalies are thus associated with an increased risk of adverse obstetric outcomes, including preterm birth, preterm premature rupture of membranes, breech presentation, caesarean delivery, and intrauterine growth restriction. Among these anomalies, the unicornuate uterus represents a rare form resulting from incomplete development of one Müllerian duct. It is particularly associated with obstetric complications, especially fetal malpresentations, due to reduced uterine volume and the anatomical constraints it imposes [2]. We report the case of a 28-year-old parturient with breech presentation discovered intraoperatively in a unicornuate uterus.

Case Presentation

A 28-year-old woman, gravida 1 para 0, with no significant past medical or surgical history, presented to the obstetric emergency department at 40 weeks of gestation with complaints of regular uterine contractions. This was her first antenatal consultation, indicating a poorly monitored pregnancy.On clinical examination, the patient was found to be in the active phase of labor. The cervix was anterior, soft, dilated to 2 cm, and 40–50% effaced. The membranes were intact, and the fetus was in a high, mobile incomplete breech presentation. Obstetric ultrasound revealed a singleton viable pregnancy with positive fetal cardiac activity. The fetus was in breech presentation, with a fundal placenta. Fetal biometry corresponded to 40 weeks of gestation but showed evidence of intrauterine growth restriction, with an estimated fetal weight of 2525 grams. Electronic Fetal heart rate Monitoring (EFM) was initially normal. The patient was admitted to the labor ward for expectant management with close monitoring using a partogram. However, during labor, fetal heart rate abnormalities appeared, including decelerations, indicating a non-reassuring fetal status. An emergency cesarean section was performed within 20 minutes. A female newborn was delivered, weighing 2400 grams, with an Apgar score of 10/10 at 1 and 5 minutes. Intraoperative findings revealed a unicornuate uterus **(Figure 1 and 2)**. The postpartum course was uneventful, and both mother and newborn had a favorable outcome. The newborn was discharged with the mother in good condition.

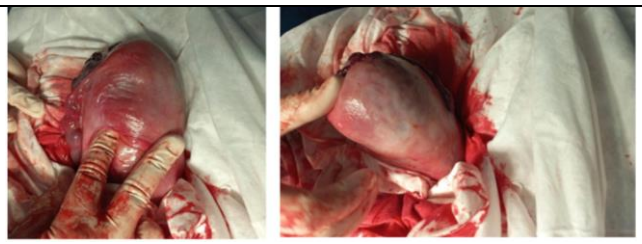

Figure 1 and 2: Intraoperative view of a unicornuate uterus.

Discussion

The prevalence of congenital uterine anomalies in the general population is estimated at 1-4% according to various studies. However, this prevalence remains inexact due to the asymptomatic nature of these malformations. Diagnosis is most frequently made in patients followed for infertility, recurrent miscarriages, or preterm births. In our case, the patient was asymptomatic in daily life and during this pregnancy, and the diagnosis was made during the ceasarean section [3]. According to the ESHRE/ESGE classification, a unicornuate uterus corresponds to a class II uterine anomaly and may

or may not be associated with a rudimentary horn [4]. Malpresentation, particularly breech presentation, is significantly more frequent in uterine malformations due to distorted uterine cavity morphology and reduced intrauterine volume, which limit fetal mobility and normal cephalic engagement. Breech presentation at term is therefore a well-documented complication in unicornuate uterus [1,5]. In our case, the fetus presented in an incomplete breech position, consistent with this pathophysiological mechanism. Additionally, IUGR is commonly reported in malformed uterus, likely due to suboptimal uteroplacental perfusion and reduced endometrial surface area. Although fetal biometry in this case was near term (estimated at 40 weeks with an EFW of 2525 g), the presence of suspected growth restriction may reflect chronic uterine constraint or placental insufficiency, both of which are frequently associated with Müllerian anomalies [6]. The management of breech presentation at term remains controversial. However, in the presence of labor, non-reassuring fetal status, and additional risk factors such as uterine malformation and suspected IUGR, cesarean section is widely recommended. The appearance of pathological fetal heart rate tracing with recurrent decelerations justified an emergency cesarean section in this case, in accordance with standard obstetric guidelines [7]. The incidental discovery of a unicornuate uterus during surgery underscores the importance of considering uterine anomalies in cases of unexplained malpresentation or obstetric complications. Preconception or antenatal diagnosis via ultrasound or MRI remains challenging, especially in low-resource or poorly followed pregnancies, as illustrated in this case. Overall, this observation highlights the association between unicornuate uterus, breech presentation, and intrapartum fetal distress, emphasizing the need for heightened vigilance and individualized obstetric management.

Conclusion

Unicornuate uterus is a rare Müllerian duct anomaly often diagnosed incidentally and associated with significant obstetric complications. This case illustrates the strong association between uterine malformation, breech presentation, and intrapartum fetal distress. The absence of antenatal follow-up delayed the diagnosis and limited early risk stratification. Careful intrapartum monitoring allowed timely recognition of fetal compromise, leading to an emergency cesarean section with a favorable maternal and neonatal outcome. This case highlights the importance of considering uterine anomalies in cases of malpresentation and reinforces the need for individualized obstetric management and close fetal surveillance in high-risk pregnancies.

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