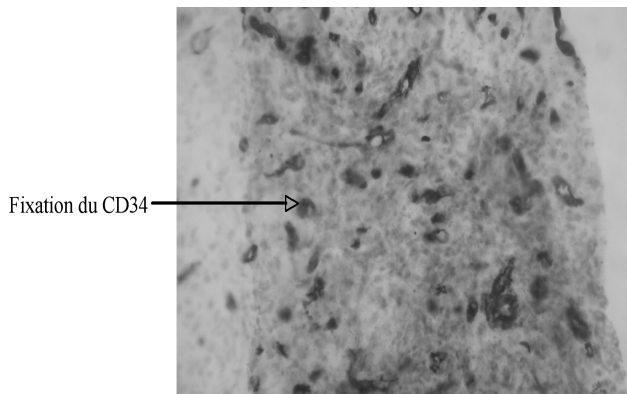


favorable. Deux mois plus tard, il développait de la fièvre et des douleurs de l'hypochondre droit avec une réapparition du syndrome inflammatoire biologique. Un deuxième scanner était réalisé, objectivant des signes de surinfection de la nécrose au sein de la masse hépatique. Par ailleurs, il n'existait plus de signes de sigmoïdite diverticulaire. Une antibiothérapie à large spectre était instaurée, permettant une amélioration clinico-biologique et radiologique. Devant l'âge jeune du patient et une tumeur hépatique volumineuse devenant symptomatique on décidait d'opter pour un traitement chirurgical à distance de l'épisode infectieux.

**Figure 3 :** Examen anatomopathologique : Fibrose hépatique avec infiltrat inflammatoire et cellules d'aspect épithélioïde



### Conclusion

Notre observation illustre une localisation exceptionnelle de l'hémangio-endothéliome épithélioïde et pose le problème du diagnostic différentiel face à cette lésion en cas de pathologies infectieuses ou néoplasiques associées. Le choix thérapeutique doit être discuté au cas par cas et repose essentiellement sur le caractère symptomatique ou non de la tumeur.

### Références

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*Sami Karoui (1), Zeineb Ben Ali (1), Hayfa Azzouz (2), Meriem Serghini (1), Nadia Ben Mustapha (1), Emna Menif (3), Slim Haouet (2), Jalel Boubaker (1), Azza Filali (1)*

1 : Service de Gastroentérologie A. Hôpital la Rabta. Tunis.

2 : Laboratoire d'Anatomie Pathologique. Hôpital la Rabta. Tunis.

3 : Service d'Imagerie Médicale. Hôpital la Rabta. Tunis.

Faculté de Médecine de Tunis.

Université Tunis El Manar

## Stopped pregnancy in a rudimentary horn at 12 week gestation

The classification of the American Society for Reproductive Medicine (ASRM) divides the unicornuate uterus into four groups: unicornuate uterus with communicating rudimentary horn, unicornuate uterus with non communicating rudimentary horn and with cavity, with non communicating rudimentary horn and without cavity, and no rudimentary horn but an isolated unicornuate uterus [1, 2]. Gynaecological and obstetrical complications may occur in the two first groups. Pregnancy in rudimentary horn remains a rare event. It is estimated that 600 to 700 rudimentary horn pregnancies have been reported worldwide up to now [3, 4]. Only one case after in vitro fertilization and embryo transfer have been reported [5]. During pregnancy the risk of rupture in a non-communicating horn is 70 % [6]. However a successful outcome for pregnancy, although very rare, has been reported [7]. Maternal mortality is less than 0.5 % and the last case was reported in 1960 [8]. We report, here, a case of women presenting with stopped pregnancy within non-communicating rudimentary horn.

### Case report

A 32 years old primigravida was examined at 12 weeks gestation by ultrasound in our service. There was no history of abdominal or pelvic pain or vaginal bleeding. Ultrasound scan showed a gestation sac with single viable fetus with a crown-rump length consistent with 12 weeks gestation. On the right side of the gestational sac a normal uterus with a thick endometrium was observed. Pelvic examination revealed a single cervix with normal size uterus deviated to the right side. On the left side, a soft painful 5 x 6 cm mass was palpable. Movements of the mass were conducted to the cervix. Diagnoses made were: bicornuate uterus or unicornuate uterus with rudimentary horn. One day later, ultrasonography control showed a stopped pregnancy. The patient was offered MRI to further clarify her uterine anatomy. The confirmed diagnosis was unicornuate uterus with pregnancy within non-communicating rudimentary horn (Figures 1 and 2). Bilateral kidneys were normal.

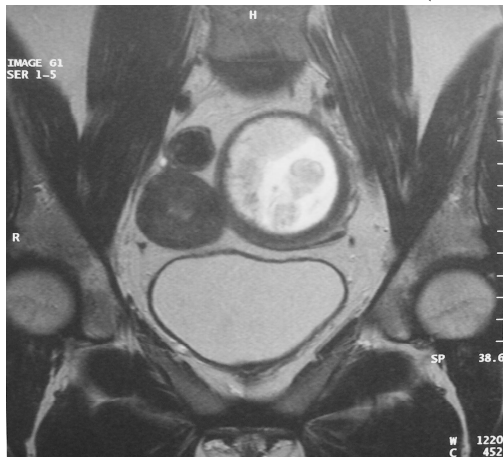
After discussions with the patient, surgical intervention for treatment was decided. Laparoscopy followed by laparotomy, confirmed a left non-communicating rudimentary uterine horn attached to a normal right horn by a muscular thick pedicle which was around 3 cm length (Figures 3, 4 and 5). The wall of rudimentary horn was thin. Bilateral tubes and ovaries were normal and healthy. The rudimentary horn was excised with the ipsilateral fallopian tube (Figure 6). Left ovary was left as such. Patient had an uneventful postoperative recovery and was authorized to leave after 4 days.

### Conclusion

Pregnancy in rudimentary horn is a rare but a serious event threatening maternal life. Rupture of rudimentary horn requires urgent management and surgery to stop haemorrhage and to remove rudimentary horn with ipsilateral Fallopian tube. The

same treatment should be undertaken when diagnosis was made before rupture. That is why we insist on first trimester pelvic examination and sonography, to early diagnoses, of such pathology and reduce maternal morbidity.

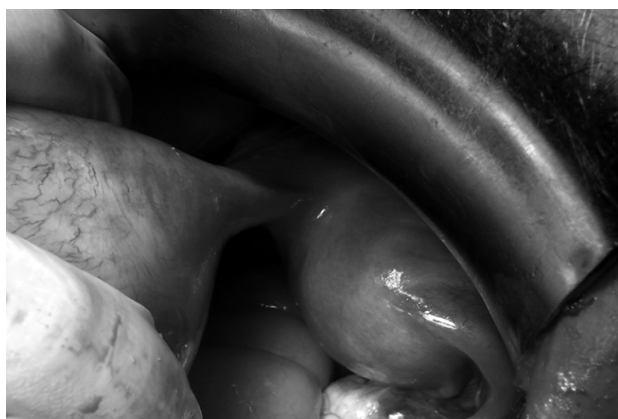
**Figure 1:** Coronal MRI of pelvis showing right and left uterine horns. Existence of degenerating gestational tissue and fetus in the left uterine horn which has a thin wall (white arrow)



**Figure 2 :** Sagittal MRI of pelvis showing right and left uterine horns. Existence of degenerating gestational tissue and fetus in the left uterine horn which has a thin wall (white arrow).



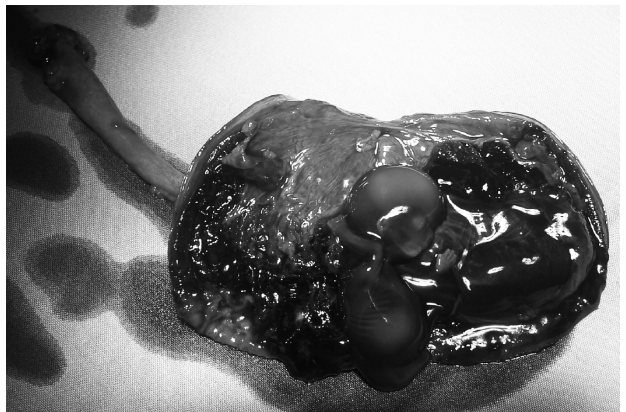
**Figure 3 :** Normal right corn attached to a rudimentary left horn by a muscular thick pedicle



**Figure 4:** Distended left rudimentary horn with the ipsilateral Fallopian tube and ovary.



**Figure 5:** Fetus within the removed rudimentary horn with its ipsilateral fallopian tube



**Figure 6 :**