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## Secondary infertility with bilateral cornual block in bicornuate uterus: A case report treated with Homoeopathic medicines

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### Abstract

**Introduction:** Bilateral tubal blockage is one of the major causes of infertility by preventing successful passage of the ovum to meet the sperm. Bicornuate uterus is a congenital uterine anomaly often associated with increased rate of spontaneous abortion and infertility. We hereby report a case of secondary infertility with bilateral cornual block in a bicornuate uterus which was under gone hysteroscopic septoplasty by laparoscopic intervention. But after one year continuous Homoeopathic treatment she got pregnancy and delivered a child of full term.

**Case presentation:** A 27 years old patient of secondary infertility presented with a history of spontaneous abortion in her first gestation 5 years ago. Afterwards she had been investigated and was found to be having Bicornuate uterus with bilateral tubal blockage as shown by hysterosalingography (HSG) and undergone operative hysteroscopic septoplasty by laparoscopic intervention. But because of bicornual blockage she was unable to conceive. Under homoeopathic treatment HSG finding not only shows evidence of spillage of contrast on left side and visualization of the right fallopian tube, but she got pregnancy and delivered a full term baby.

**Conclusion:** Even after septoplasty, bilateral tubal blockage itself is a challenge to get pregnancy. But in the present case, it has been achieved by this homoeopathic treatment.

**Keywords:** Secondary infertility, bilateral cornual block, bicornuate uterus, homoeopathic treatment

### Introduction

35 to 40% of infertility in women is due to tubal causes. These include tubal obstruction, narrowing, dilatation as well as conditions that alter tubal function due to changes in the tubal mucosal lining or its muscular wall. Tubal blockage can involve the proximal (cornual) part, the mid part or the distal part. HSG is a very effective technique to assess this tubal status<sup>[1]</sup>.

Tubal obstruction is the important factor for secondary infertility than those with primary infertility<sup>[2]</sup>. On the other side, congenital uterine malformation is estimated to be 3-5% in general population. Bicornuate uterus is the most common type of congenital uterine malformation. It is the result of defective lateral fusion of the paramesonephric ducts at about the tenth week of intrauterine life around the fundus. Women with this congenital defect known to be associated with infertility, spontaneous abortion, preterm birth, intrauterian growth retardation, preterm delivery, preterm prelabour rupture of membranes, breech presentation and increase rate of caesarean delivery<sup>[3-5]</sup>. On the other hand, fertility is not considered to be impaired in bicornuate uterus, but on its gestational capacity<sup>[6]</sup>. Though, hysteroscopic metroplasty is said to be contraindicated in the case of bicornuate uterus as there is possibility of uterine perforation as the external uterine contour is concave and uterine horns are widely divergent<sup>[7]</sup>, but, currently it is considered as safe, simple method of choice for septate uterus<sup>[8, 9]</sup>. Hysteroscopic septoplasty is considered to be effective in a pregnancy rate of 60% of those women suffering from infertility with having septate uterus<sup>[10]</sup>.

### Patient information

A 27 years old married woman (housewife) of a middle class family from the state of Bihar who had complain of secondary infertility, presented to the Obstetrics and Gynaecology outpatient department (OPD) of National Institute of Homoeopathy (NIH), Salt lake, Kolkata on 09/02/2016. She was married for six years and had a history of spontaneous abortion at first

trimester (in one month of gestational age) in her first pregnancy which was five years ago. She came with a HSG report (as on dated 23/11/2015) [Figure – 1] which showed Bicornuate uterine cavity with bilateral cornual block. She was undergone laparoscopic dye test with hysteroscopic septoplasty on 18/12/2015 and advised for In-Vitro Fertilization (IVF) because of bilateral cornual block. But, patient and her family members decided to take a chance in Homoeopathy.



**Fig 1:** HSG (as on 23/11/2015): Bi-cornuate uterine cavity and bilateral cornual block.

**Clinical findings**

As per her detail case history which was taken on 09/02/2016, menstruation was irregular. It was too long, profuse, blackish and clotted. In sexual history, there was pain and burning during and after coition. There was also burning sensation during and after urination and urge for stool immediately after waking in the early morning. Thermal reaction was hot. Under general modality, aggravation in rainy season, this was related to upper respiratory tract affections and nonspecific joint pain. Mentally she was very depressed, irritable, introvert and also had history of suppressed grief and anger.

**First prescription**

On dated 09/02/2016 - *Natrum sulphuricum* 30c, 200c and 1M were prescribed - one dose each for three consecutive days, followed by placebo.

**Follow up**

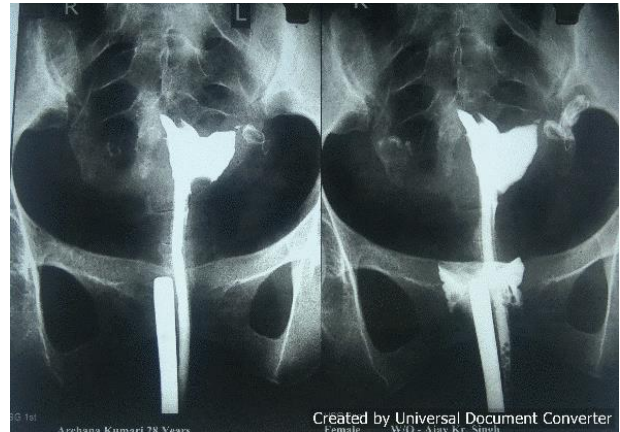
On 15/3/2016 – Irregular menstruation continued. After 22/01/2016 it appeared on 24/02/2016, and then on 04/3/2016. Menstrual discharge was blackish with clotted. Placebo was prescribed.

On 21/4/2016 – Next menstruation appeared on 04/4/2016 after 04/3/2016. Pain during and after coition were decreased. *Thiosinaminum* 6c was prescribed, twice daily for one month.

On 18/5/2016 – Menstrual period was regular. But it was dark and clotted especially in the morning. No burning during urination but there was intense burning after coition. Thirst was less. Patient felt chilliness and there was dream of falling from height. *Thuja occidentalis* 1M was prescribed in 3 doses, once daily for three consecutive days, followed by placebo. She was also advised to repeat HSG again.

On 07/12/2016 – Menstruation was regular. It was reddish, but small clots found only on 2<sup>nd</sup> day. Leucorrhoea was

appeared 2 days before menstruation. Burning during urination was decreased and there was no pain or burning during and after coition. Stool was regular, but it was immediately after rising from sleep in the morning. Thirst was improved. Mentally she felt better as she was able to tolerate anger. In HSG (as on 02/12/2016) [Figure - 2]: there was normal uterine cavity with shows evidence of spillage of contrast on left side and visualization of the right fallopian tube also. *Thuja occidentalis* 10M was prescribed in 2 doses, once daily for two consecutive days, followed by placebo.



**Fig 2:** HSG (as on 02/12/2016): Normal uterine cavity, contrast seen in both tubes, localized spill seen on the left side

12/4/2017 – In ultrasonography (USG) (as on 10/4/2017) [Figure - 3], single live intrauterine foetus was found with 13 weeks maturity. She was advised to take regular antenatal care from nearby health centre at the area of her residence.

**Image Centre ULTRASOUND**

Mill Road (Goenka Market), Khagaria

Dr. Anuj Kumar MBBS, Sonologist      Contact : 9709827508, 9431418158, 8804213951      Dr. S. Vivekanand MBBS, M.D. (Radio-Diagnosis) Assoc. Prof. (Kathar Medical College) (Formerly at P.G.I. Chandigarh)

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NAME : ARCHANA DEVI      DATE: 10-04-17

REF : DR. MRS. J. SINHA MBBS

**USG WHOLE ABDOMEN**

LIVER - MEASURES 128 mm IN SIZE WITH NORMAL OUTLINE AND ECHOTEXTURE. I. H. B. R. NOT DILATED.

NO ANY FOCAL PARENCHYMAL LESION SEEN

HEPATIC VEINS ARE NORMAL IN CALIBRE AND ECHOTEXTURE.

PORTA - PORTAL VEIN IS NORMAL.

PANCREAS - IS NORMAL.

GALL BLADDER - IS PHYSIOLOGICALLY DISTENDED. NO LUMEN ECHO SEEN

SPLEEN - IS NORMAL IN SIZE WITH OUTLINE AND ECHOTEXTURE.

KIDNEY - BOTH KIDNEY SHOW NORMAL IN SIZE AND OUTLINE

CMV MAINTAINED

SINUS ECHOS ARE COMPACT

URINARY BLADDER - IS PARTIALLY FILLED WITH NORMAL ECHOTEXTURE.

UTERUS- SINGLE LIVE INTRAUTERINE FETUS WITH UNSTABLE LIE.

F. H. R. 165 B/M      MOVEMENT - NORMAL

PRESENTATION - UNSTABLE      PLACENTA - POSTERIOR, UPPER UT SEG

LIQUOR - ADEQUATE.

GESTATIONAL AGE-

BPD	25 mm	14 W 2 D
AC	74 mm	14 W 0 D
FL	10 mm	13 W 6 D

AVERAGE - 13 W      F.W. - 78 gm      E.D.D - 11-10-17 + 14 D

**IMP - SINGLE LIVE INTRAUTERINE FETUS WITH 13 W MATURITY.**

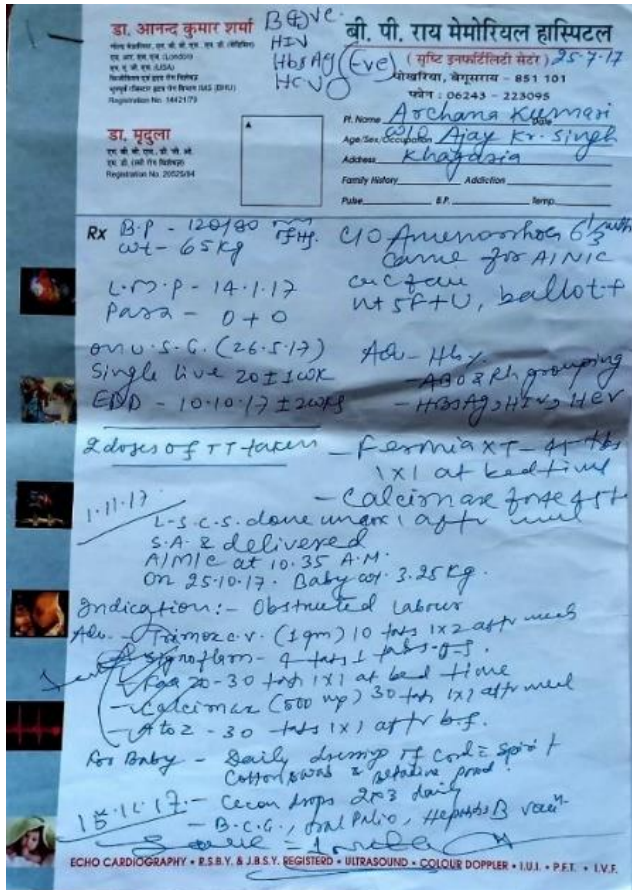
*(Signature)*

Please correlate clinically & with History

12<sup>o</sup> Ultrasound Examination is just a play of image. Interpretation may vary.  
 13<sup>o</sup> It is recommended that report may co-related clinical sign & symptoms and others clinical investigation.  
 14<sup>o</sup> Report not valid for medical legal purpose.

**Fig 3:** USG (as on 10/4/2017): Single live intrauterine foetus with 13 week maturity.

And ultimately she delivered a full term baby boy on 25/10/2017 [Figure - 4].



**Fig 4:** Reports showing delivery of a baby boy at full term weighing 3.25 kg - from a private local hospital

**Discussion & Conclusion**

In the homoeopathic case history secondary infertility with bilateral tubal blockage in bicornuate uterus as well as other particulars and generalities indicate syco-syphilitic miasmatic background. After considering this background with other indications *Natrum sulphuricum* was prescribed in three increasing potencies which were advised to take for three consecutive days. After that the medicine *Thiosinaminum* was prescribed purely on the basis of its patho-physiological action. Lastly *Thuja occidentalis* was selected on the basis of same miasmatic as well as other indications related to particulars and the generalities of that particular period of time. By this way, after taking continuous homoeopathic treatment for one year, she got pregnancy as found in USG (on dated 10/4/2017) which showed single live intrauterine foetus with 13 weeks maturity and finally on 15/10/2017 she delivered a baby boy at full term of 3.25 kg. It was only possible after opening of cornual block as found in HSG (on 02/12/2016) which showed normal uterine cavity with evidence of spillage of contrast on left side and visualization of the right fallopian tube.

This case signifies effectivity of homoeopathic medicines on secondary infertility by improving menstrual irregularity with other mental as well as physical irregularities and ultimately opening the cornual block.

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