

DISCUSSION

Laparoscopic hysterectomy in a double uterus is quite challenging as the anatomy is a bit different from the normal uterus. In the cases of müllerian anomalies, dedicated preoperative imaging of the renal tract ruled out urinary tract abnormalities that may be associated with congenital müllerian duct anomalies (MDAs). Renal agenesis is seen in 30% of müllerian anomalies. Hence accurate diagnosis should be made and proper planning prior to surgery should be undertaken to avoid intraoperative complications.

Accurate knowledge of the course of ureter is required for surgeons starting on complex laparoscopic, open and vaginal surgery.

Both the ureters are identified in the pelvic side walls and marked down throughout the course. Then the surgery is begun. Along with dissection of side walls, bladder flap is dissected widely to facilitate a wider colpotomy. To separate the bladder we can retro fill with CO₂, methylene blue to delineate the plane and create a wider bladder flap. Then after identifying proper course and uterine anatomy we can proceed with step wise cutting of uterine supports making sure that we are closer to uterus.

The Key points of surgical safety are identification of ureter (Bilateral ureterolysis), and ligating the uterine arteries at their origin, which would be done only after proper placement of colpotomy cup which would allow proper division of uterine arteries.

CONCLUSION

Minimally invasive procedure is ideal for patients with müllerian duct anomalies. Identifying the ureters and additional renal anomalies is the foremost step to complete hysterectomy safely in these patients. Planning and mental preparedness is required while approaching complex surgical cases which are the key to successful management of the cases that deviate from the "norm".

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