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Term Pregnancy in a Robert's Uterus: A Case Report

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Abstract **Case Report**

This case report presents a rare instance of a term pregnancy in a Robert's uterus, a rare Müllerian duct anomaly characterized by an asymmetric septate uterus with one obstructed hemicavity and a normal external uterine contour. A 27-year-old woman, previously diagnosed with a septate uterus and with a history of gestational diabetes, presented in spontaneous labor at term. Ultrasound confirmed a breech pregnancy in a bicornuate uterus. Due to malpresentation and the uterine anomaly, a cesarean section was performed, resulting in the delivery of a healthy male neonate with a triple nuchal cord. Despite the uterine anomaly, the pregnancy reached term with mild fetal growth restriction, a common complication in such cases. This report underscores the feasibility of successful term pregnancy in Robert's uterus with early diagnosis and careful monitoring. Imaging, especially ultrasound and MRI, plays a crucial role in diagnosis, and cesarean delivery remains the safest option when anatomical abnormalities or malpresentation are present.

Keywords: Robert's Uterus, Term pregnancy, Fetal growth restriction, Asymmetric septate uterus.

INTRODUCTION

Congenital uterine anomalies are often associated with recurrent miscarriages, preterm deliveries, abnormal fetal presentations, and infertility. Among them, the septate uterus is the most frequent and the one most amenable to hysteroscopic correction, usually resulting in favorable reproductive outcomes. A rare variant of this anomaly is Robert's uterus, first described by the French gynecologist Robert in 1969. It is a rare Müllerian duct anomaly characterized by an asymmetric septate uterus in which one hemicavity is obstructed, leading to hematometra, while the contralateral hemicavity communicates normally with the cervix. The external contour of the uterine fundus remains normal [1,2]. We report a rare case of a term pregnancy in a Robert's uterus, highlighting the diagnostic and therapeutic challenges encountered.

CASE REPORT

A 27-year-old woman with a history of gestational diabetes managed by diet presented at term in spontaneous labor. Obstetric history included a diagnosis of a septate uterus in 2023. She was gravida 3, para 3, with one live birth via vaginal delivery and one neonatal death due to prematurity.

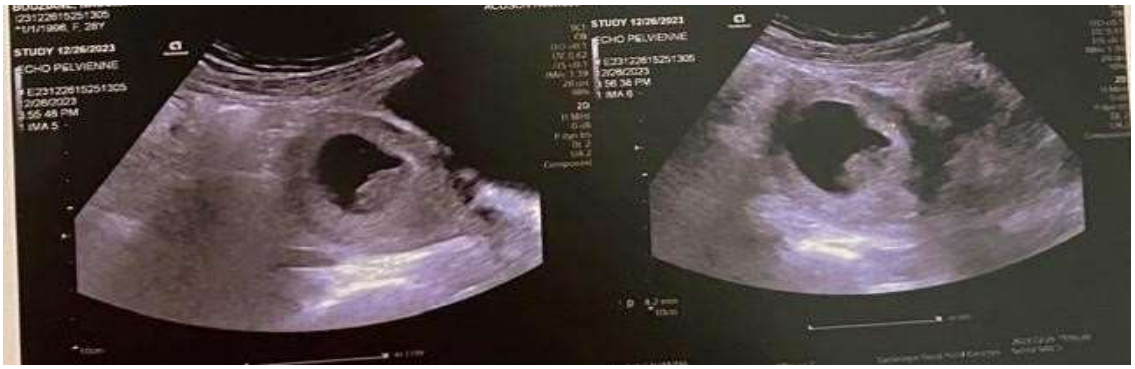

Image 1: An intrauterine gestational sac in one of the cavities, the other horn empty First-trimester ultrasound showed a single intrauterine pregnancy within a Robert's uterus

On admission, clinical examination revealed a stable patient with normal vital signs and no neurological symptoms. Obstetrically, she was in labor with 3 cm cervical dilation. Her membranes had ruptured three hours earlier, with clear amniotic fluid. Fetal presentation was breech and cardiotocography was reassuring.

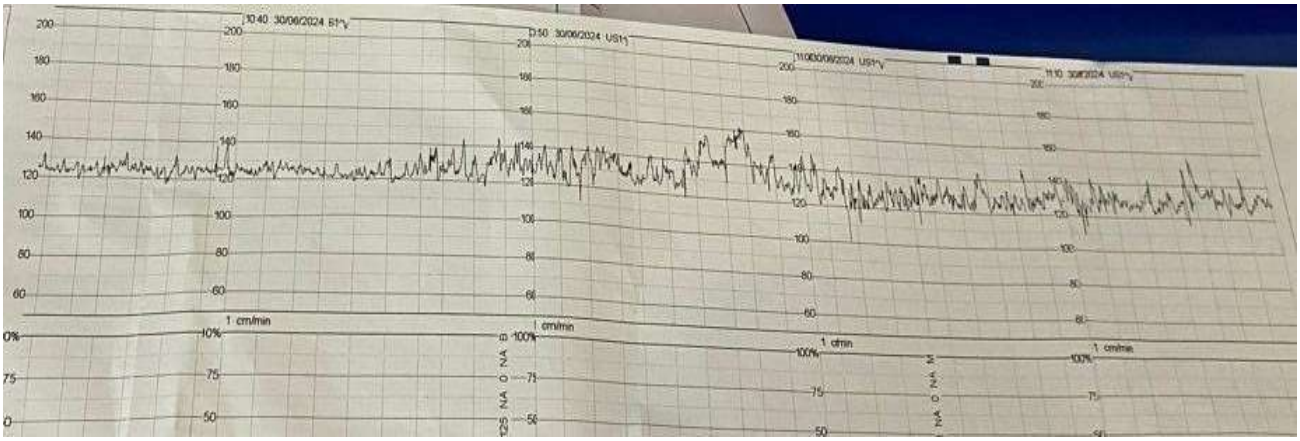

Image 2: Normal fetal cardiotocography

Initial blood tests revealed microcytic hypochromic anemia (hemoglobin 10 g/dl), platelet count of 200,000/mm³, blood group A Rh-positive, and normal liver and kidney function tests.

Obstetric ultrasound confirmed a viable singleton breech pregnancy within a bicornuate uterus, with a biparietal diameter of 87 mm, well-flexed fetal head, fundal placenta, normal amniotic fluid volume, and estimated fetal weight of 2200 g.

Image 3: Per operative image of Robert Uterus

Image 4: Roberts utérus

Due to the malpresentation and uterine malformation, the patient underwent a cesarean section. A live male neonate weighing 2400 g was delivered via breech extraction, with Apgar scores of 10/10. A triple nuchal cord was discovered during delivery.

DISCUSSION

Despite the anatomical complexity, term pregnancy in Robert's uterus is possible with appropriate care and monitoring [1]. Management often involves careful monitoring during pregnancy and a planned delivery strategy. In this case, cesarean delivery was indicated due to breech presentation and the uterine malformation, which aligns with current recommendations [1].

Although MRI is the best diagnostic tool, our case was diagnosed via ultrasound, showing the importance of imaging even in routine pregnancy follow-ups. Literature also highlights that spontaneous conception is possible in 85% of cases with such anomalies, which matches our patient's history of spontaneous pregnancies. [2]. Our patient had a fetus in breech presentation with an estimated weight of 2200 g, and a birth weight of 2400 g—consistent with mild growth restriction.

Studies report that:

- Breech or transverse presentations occur in 40–50% of cases due to limited uterine space.
- Preterm labor affects about 20–25% of patients with Müllerian anomalies.
- Fetal growth restriction is found in 15–20% of cases, attributed to reduced blood flow. [3]

In our case, the pregnancy reached full term with a breech presentation and required cesarean delivery. This outcome, although favorable, aligns with the risks described in the literature. [4] In Robert's uterus, the pregnancy usually develops in one hemicavity while the other remains obstructed. This anomaly is rare and often leads to complications such as miscarriage, preterm labor, fetal growth restriction, and abnormal fetal presentation. [5]

CONCLUSION

This case illustrates the possibility of a successful term pregnancy in Robert's uterus despite its rarity and complexity. Early diagnosis and careful monitoring throughout pregnancy are essential to optimize outcomes. Cesarean delivery remains the safest option in the presence of malpresentation or anatomical constraints. Greater awareness of this anomaly is crucial for timely recognition and management.

REFERENCES

1. Heinonen PK, Saarikoski S, Pystynen P. Reproductive Performance of Women with Uterine Anomalies: An Evaluation of 182 Cases. Acta Obstet Gynecol Scand. 1982;61(2):157-62.
2. Nasri MN, Setchell ME, Chard T. Transvaginal ultrasound for diagnosis of uterine malformations. BJOG. 1990;97(11):1043-5.
3. Bafagih DA. Robert's uterus | Radiology Case | Radiopaedia.org. https://radiopaedia.org/cases/roberts-uterus-1
4. Lewis D, Downe S, Panel FIFMEC. FIGO consensus guidelines on intrapartum fetal monitoring: Intermittent auscultation. Int J Gynecol Obstet. 2015;131(1):9-12.
5. Pinki P, Amit A. Doppler in High-Risk Pregnancy and Its Correlation with Feto-Maternal Outcomes: A Prospective Study. Cureus. 2024;16(3):e56751.