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CASE REPORT

Bicornuate Uterus with Recurrent Miscarriage Following a Successful Term Pregnancy: A Case Report

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Abstract: Bicornuate uterus is an uncommon congenital Müllerian duct anomaly resulting from incomplete fusion of the paramesonephric ducts and is associated with adverse reproductive outcomes, including recurrent pregnancy loss, preterm birth, and malpresentation. However, some affected women may achieve successful pregnancies before the anomaly becomes clinically apparent, creating diagnostic challenges that can delay recognition and treatment. We report the case of a 28-year-old multiparous woman from rural Southwestern Uganda who presented with recurrent pregnancy loss following a previously uncomplicated term vaginal delivery. Ultrasonographic evaluation revealed a bicornuate unicollis uterus after two consecutive first-trimester miscarriages. Diagnostic uncertainty persisted throughout, as definitive differentiation from a septate uterus was not possible given the imaging limitations in our setting. The diagnosis was complicated by limited access to advanced imaging modalities such as three-dimensional ultrasonography, hysteroscopy, and magnetic resonance imaging (MRI), highlighting challenges commonly encountered in low-resource environments. Given her adverse reproductive history, desire for future fertility, and the lack of access to laparoscopic surgical services within our setting, she underwent an open Strassman metroplasty, which was technically successful in restoring a unified uterine cavity. The postoperative course was uneventful, and extensive counseling was provided regarding fertility expectations, contraception, and timing of future conception. At the time of reporting this case, she remained clinically stable at 2 months of follow-up, although reproductive outcomes following surgery could not yet be assessed, and definitive conclusions regarding reproductive benefit cannot be drawn at this stage. This case highlights the paradoxical presentation of bicornuate uterus with an initial successful term pregnancy followed by recurrent miscarriage, underscores the diagnostic and management barriers faced in resource-constrained settings, and emphasizes the importance of considering congenital uterine anomalies in women presenting with secondary recurrent pregnancy loss despite a previously favorable obstetric history.

Keywords: bicornuate uterus, recurrent pregnancy loss, müllerian duct anomalies, metroplasty, resource-limited settings, Southwestern Uganda

Introduction

Congenital Müllerian duct anomalies represent a spectrum of developmental abnormalities resulting from abnormal formation, fusion, or resorption of the Müllerian ducts during embryogenesis.[1–5] These anomalies include Müllerian agenesis, unicornuate uterus, uterus didelphys, bicornuate uterus, septate uterus, arcuate uterus, and complex or unclassified anomalies.[3,4] Among these, a bicornuate uterus is characterized by incomplete fusion of the Müllerian

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ducts, leading to a partial uterine duplication with two symmetric uterine horns and a single cervix in most cases.[1,3,6–8] Although relatively uncommon in the general population, occurring in approximately 0.1–0.5% of women, it is clinically significant due to its strong association with adverse reproductive outcomes, including recurrent pregnancy loss, preterm birth, malpresentation, and infertility.[2,5,9,10]

Recurrent pregnancy loss remains a multifactorial clinical challenge, and structural uterine anomalies account for a substantial proportion of cases after endocrine, genetic, and immunological causes have been excluded.[1,7,11–13] The bicornuate uterus is most consistently associated with mid-trimester loss and preterm delivery, whereas its role in first-trimester miscarriage remains contested; some authors attribute an association to impaired uterine distensibility and abnormal implantation dynamics, while others have found first-trimester loss to be more strongly linked to septate rather than bicornuate uterus, underscoring the importance of accurate anomaly classification before attributing pregnancy loss to a specific uterine malformation.[14–17] Despite this association, the condition often remains undiagnosed until reproductive failure prompts further investigation, especially in settings where routine evaluation of uterine anatomy is not standard practice.[1,3,17,18]

Accurate diagnosis of bicornuate uterus requires high-resolution imaging modalities such as three-dimensional transvaginal ultrasonography or magnetic resonance imaging, which allow precise delineation from other Müllerian anomalies such as septate uterus, a distinction that is critical for appropriate management.[2,4,9,11,19] However, in low-resource settings, reliance on two-dimensional ultrasonography, limited imaging expertise, and lack of advanced diagnostic tools frequently contribute to misclassification or delayed diagnosis.[2,18,19] This diagnostic uncertainty may directly impact clinical decision-making and delay definitive management.[19]

Current classification systems, including the American Society for Reproductive Medicine (ASRM) classification and the European Society of Human Reproduction and Embryology/European Society for Gynaecological Endoscopy (ESHRE/ESGE) classification, differentiate bicornuate from septate uterus primarily on the basis of external fundal contour and the depth and angle of the internal fundal indentation, with a bicornuate uterus typically demonstrating an external fundal cleft exceeding 1 cm and a wide internal indentation angle, in contrast to the smooth external contour characteristic of a septate uterus.[20,21]

Surgical correction, most commonly through Strassman metroplasty, is considered in selected patients with bicornuate uterus and poor reproductive outcomes.[4,17,22,23] The procedure aims to unify the uterine cavity and improve pregnancy outcomes, although evidence is largely derived from small case series and observational studies. Because the indications for surgery, including the minimum number of pregnancy losses that justifies intervention, are not established by randomized controlled trial evidence, the decision to operate remains a matter of individualized clinical judgment rather than firm evidence-based consensus.[4,14,23] Importantly, access to such specialized reproductive surgery remains limited in low-income and resource-constrained settings, where patients often present late and management options are restricted.[4,19]

This case report describes a woman with a unique reproductive history of a successful term pregnancy followed by recurrent first-trimester miscarriages secondary to a bicornuate uterus. It highlights the diagnostic challenges encountered in a resource-limited setting, the surgical management undertaken, and the complexities surrounding counseling and reproductive planning. The report underscores the importance of early recognition of Müllerian duct anomalies and the need to strengthen diagnostic and surgical capacity for these anomalies in low-resource environments.

Case Presentation

A 28-year-old woman, Para 1+2 (one prior term vaginal delivery and two subsequent first-trimester miscarriages), from a rural district in Southwestern Uganda, presented to the gynecology clinic at Kabale Regional Referral Hospital with secondary recurrent pregnancy loss. She reported that her main concern was: “I had one previous successful pregnancy, but the two that followed both ended in miscarriages”. She had no known chronic medical illnesses, no history of sexually transmitted infections, and no exposure to teratogenic medications. There was no family history of congenital uterine anomalies or recurrent pregnancy loss, and she was in a stable monogamous marriage with spontaneous conception in all pregnancies.

Her obstetric history showed an initially uncomplicated reproductive course. Her first pregnancy progressed normally to term and resulted in a spontaneous vaginal delivery at Kabale Regional Referral Hospital without any intrapartum or postpartum complications. In contrast, her subsequent two pregnancies ended in spontaneous first-trimester losses at approximately 10–12 weeks of gestation. These losses were not associated with fever, vaginal trauma, uterine instrumentation, or other identifiable precipitating factors. No uterine abnormalities were reported on abdominal ultrasound during the previous pregnancies, which explains why the anomaly was not detected earlier and why the diagnosis and management were delayed. She denied chronic pelvic pain, dysmenorrhea, or cyclical symptoms suggestive of endometriosis, and there were no clinical features suggestive of endocrine disorders such as thyroid dysfunction or polycystic ovarian syndrome.

On physical examination, she was in good general condition, afebrile, and hemodynamically stable There was no pallor, jaundice, or peripheral edema. Abdominal examination was normal, with no tenderness or palpable masses. Pelvic examination revealed normal external genitalia and a healthy vaginal canal. The cervix was normal in appearance, centrally located, and closed. Bimanual examination revealed a normal-sized, mobile uterus with no adnexal masses or tenderness.

A targeted laboratory work-up was performed within the constraints of resources in our setting, and full blood count, renal and liver function tests were normal (Table 1). Blood group and Rh typing showed O positive. Random blood glucose was within normal limits of 4.8 mmol/L. Thyroid function tests were normal, with a thyroid-stimulating hormone (TSH) level within the standard laboratory reference range, screening for syphilis (VDRL/RPR) was non-reactive, and HIV testing was negative. Urinalysis was unremarkable. Advanced investigations, including thrombophilia and antiphospholipid antibody screening, comprehensive endocrine profiling, and parental or fetal karyotyping, were not available due to limited resources, and referral to the next city with such facilities was financially impossible for the patient. Because these tests were not performed, alternative causes of recurrent first-trimester pregnancy loss could not be entirely excluded, and the contribution of the bicornuate uterus to this patient's pregnancy losses should therefore be regarded as probable rather than definitively established.

Pelvic ultrasonography, the principal imaging modality available, demonstrated features consistent with a congenital uterine anomaly suggestive of a bicornuate uterus. Findings included two distinct uterine cavities with a deep external fundal cleft exceeding 1 cm and widely divergent uterine horns, features consistent with the ASRM and ESHRE/ESGE diagnostic criteria for a bicornuate rather than a septate configuration. Myometrial continuity between the two horns was preserved, and a single cervix was identified. However, because two-dimensional ultrasonography does not reliably permit measurement of the internal intercornual indentation angle and depth, both of which are required for definitive

Table 1 Complete Blood Count and Hepatorenal Function Tests Taken on the Admission of the Patient

Complete Blood Count	Results	Reference Range	Hepatorenal Function Tests	Results	Reference Range
White blood cells	6.82 x 10^3 /uL	3.00–15.0 x 10^3 /uL	Albumin	4.65 g/dL	3.8–5.1 g/dL
Neutrophils	4.45 x 10^3 /uL	1.50–7.00 x 10^3 /uL	Total Proteins	6.91 g/dL	6.6–8.7 g/dL
Lymphocytes	1.78 x 10^3 /uL	1.00–3.70 x 10^3 /uL	Alkaline phosphatase	212 u/L	50-320 u/L
Monocytes	0.41 x 10^3 /uL	0.00–0.70 x 10^3 /uL	Alanine aminotransferase	21.9 u/L	0-41 u/L
Eosinophils	0.03 x 10^3 /uL	0.00–0.40 x 10^3 /uL	Aspartate Aminotransferase	19.4 u/L	0-40 u/L
Basophils	0.02 x 10^3 /uL	0.00–0.10 x 10^3 /uL	Gamma-Glutamyl Transferase	22 u/L	9-39 u/L
Red blood cells	4.03 x 10^6 /uL	2.50–5.50 x 10^6 /uL	Bilirubin direct	0.053 mg/dL	0.00–0.20 mg/dL
Hemoglobin	15.8 g/dL	8.0–17.0 g/dL	Bilirubin total	0.105 mg/dL	0.1–1.2 mg/dL
Mean Corpuscular Volume	90.0 fL	80.0–100.0 fL	Creatinine	0.69 mg/dL	0.60–1.00 mg/dL
Platelets	266 x 10^3 /uL	150-450 x 10^3 /uL	Urea	37.7 mg/dL	16.6–48.5 mg/dL

classification, the internal indentation angle could not be assessed, and a septate uterus could not be entirely excluded on imaging alone. Both endometrial cavities appeared normal, and the ovaries were unremarkable bilaterally, with no adnexal pathology or pelvic fluid collection. The urinary bladder had normal wall thickness but was distended with echo-free urine. The impression was a bicornuate uterus, most consistent with the bicornuate unicollis subtype. However, diagnostic certainty was limited by the absence of advanced imaging modalities such as 3D ultrasound and MRI, making definitive differentiation from a septate uterus challenging and contributing to delayed definitive diagnosis, which also delayed the management of this patient.

Based on the clinical history, imaging findings, and pattern of reproductive loss, a bicornuate uterus was considered the most likely structural contributor to this patient's secondary recurrent first-trimester pregnancy loss, while acknowledging that other unexcluded etiologies of pregnancy loss may also have contributed. The management decision was reached through multidisciplinary discussion involving the obstetrics and gynecology and surgical teams, taking into account the patient's cumulative reproductive history, her strong desire for future fertility, and the resource constraints of our setting, which limited the feasibility of prolonged expectant management or serial advanced imaging to further characterize the anomaly. Continued expectant management with further attempts at spontaneous conception was considered; however, given that the patient had already experienced two consecutive early pregnancy losses following an otherwise normal reproductive history, and considering the limited access to specialized fertility monitoring and high-risk antenatal care in this setting, the multidisciplinary team judged that continued expectant management without addressing the underlying anatomic factor carried a substantial risk of further pregnancy loss. Non-surgical alternatives were discussed with the patient and her husband, who, after extensive counseling, expressed a clear preference to proceed with surgical correction.

Following this multidisciplinary review and counseling, a decision was made to proceed with surgical correction via open Strassman metroplasty rather than a hysteroscopic or laparoscopic approach, both of which were unavailable in our setting. Unlike a septate uterus, in which the septum is typically fibrous, avascular, and amenable to hysteroscopic resection, the bicornuate configuration in this patient involved two divergent, myometrium-lined horns separated by a vascularized myometrial septum, for which an open transabdominal approach with excision of the intervening myometrial septum was considered anatomically appropriate to achieve a single, adequately vascularized uterine cavity. The patient and her husband were counseled extensively regarding the congenital nature of the anomaly, its association with recurrent miscarriage, and the potential risks and benefits of surgical intervention, including hemorrhage, infection, adhesion formation, possible uterine rupture in future pregnancies, and the need for elective caesarean section deliveries in her subsequent pregnancies. They expressed considerable anxiety regarding future fertility, particularly the likelihood of conception after surgery and the appropriate timing for attempting pregnancy. They were reassured that uterine reconstruction may improve reproductive outcomes. They were advised to delay conception for at least 3–6 months to allow adequate uterine healing and were counseled on effective contraception during this period. The importance of early antenatal booking and management in a high-risk obstetric setting for any subsequent pregnancy was also emphasized.

The patient subsequently underwent an elective open Strassman metroplasty under general anesthesia. Intraoperative findings confirmed a bicornuate uterus with two well-developed but widely divergent uterine horns and a prominent fundal cleft. Both fallopian tubes and ovaries appeared normal. A transverse fundal uterine incision was made to access both cavities, followed by opening of the uterine horns and excision of the intervening myometrial septum to create a single unified uterine cavity. The uterine walls were then reconstructed in layers using absorbable sutures to restore a single uterine fundus, with meticulous attention to hemostasis, atraumatic tissue handling, and copious irrigation to minimize the risk of postoperative adhesion formation, as a dedicated adhesion barrier was not available in our setting; estimated intraoperative blood loss was 300 mL and did not require blood transfusion, and no intraoperative complications occurred throughout the procedure (Figure 1).

The postoperative course was uneventful. The patient was closely monitored for hemorrhage, infection, and other postoperative complications and received appropriate analgesia and prophylactic antibiotics. Early mobilization was encouraged, and she recovered well, allowing discharge in stable condition after 1 week. At the time of reporting this case, the patient was 2 months post-operative and clinically stable without complications. However, reproductive

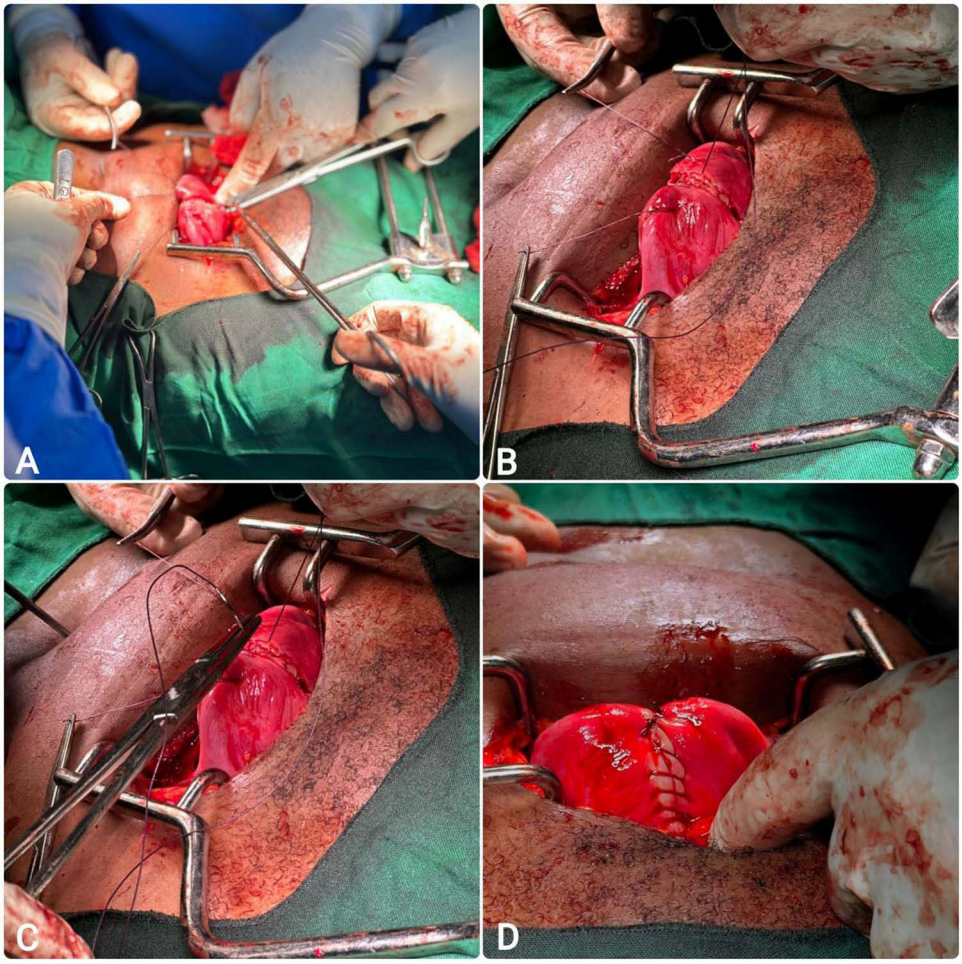

Figure 1 Intraoperative Strassman metroplasty for surgical correction of a bicornuate uterus. (**A**) Intraoperative exposure of the bicornuate uterus with commencement of the fundal uterine incision to access the malformed uterine cavity. (**B**) Opened uterine fundus demonstrating the two divergent uterine horns following incision, confirming the bicornuate configuration and allowing reconstruction of a unified cavity. (**C**) Approximation of the uterine walls during reconstruction, showing layered suturing of the uterine incision to restore normal uterine anatomy. (**D**) Completed metroplasty with successful closure of the uterine incision and restoration of a single unified uterine fundus following surgical correction of the bicornuate uterus.

outcomes following surgery could not yet be assessed, as she had not attempted conception within the recommended postoperative period.

Patient Perspective

The patient expressed that the two consecutive miscarriages following a previously uncomplicated term pregnancy were emotionally devastating and left her feeling confused, anxious, and uncertain about her reproductive future. She explained that, because she had successfully delivered her first child, she never imagined that an underlying congenital uterine abnormality could be responsible for her subsequent pregnancy losses. Receiving a diagnosis of a bicornuate uterus provided clarity and relief after months of unanswered questions. Although she was initially apprehensive about undergoing surgery and concerned about its implications for future fertility, she stated that the thorough counseling and compassionate support provided by the multidisciplinary team gave her confidence to proceed with treatment. Following her successful recovery, she expressed renewed hope of achieving another healthy pregnancy and emphasized her gratitude to the healthcare professionals involved in her care. She also wished that her experience would raise awareness among women and healthcare providers that recurrent pregnancy loss, even after a previous successful pregnancy, may be caused by an underlying congenital uterine anomaly and that timely evaluation and appropriate management can restore hope for future childbearing.

Discussion

Bicornuate uterus is a rare congenital Müllerian anomaly resulting from incomplete fusion of the paramesonephric ducts during embryogenesis and accounts for a small proportion of uterine malformations, alongside septate uterus, unicornuate uterus, uterus didelphys, arcuate uterus, and Müllerian agenesis encountered in reproductive-age women.[2,7,24] The embryological basis of this malformation is illustrated in Figure 2, which depicts failure of complete fusion and resorption of the medial septum between the paired Müllerian (paramesonephric) ducts during embryogenesis, resulting in a partially duplicated uterine fundus with two distinct horns rather than the single fused cavity of a normally developed uterus. Although many affected individuals remain asymptomatic, the anomaly has been consistently associated with adverse reproductive outcomes, including recurrent pregnancy loss, preterm birth, fetal malpresentation, cervical insufficiency, and increased rates of cesarean delivery.[4,7,12] The reproductive consequences are believed to arise from distortion of the uterine cavity, reduced uterine volume, abnormal myometrial architecture, and impaired uteroplacental development.[13,18] Nevertheless, reproductive outcomes among women with bicornuate uterus are highly variable, with some achieving successful pregnancies without intervention while others experience repeated pregnancy loss.[1,15,24–26] This heterogeneity contributes to delayed recognition of the condition and often complicates clinical decision-making.[1,4,16]

A particularly notable feature of the present case is the paradoxical reproductive history characterized by a successful uncomplicated term pregnancy preceding two consecutive miscarriages. Existing literature predominantly describes

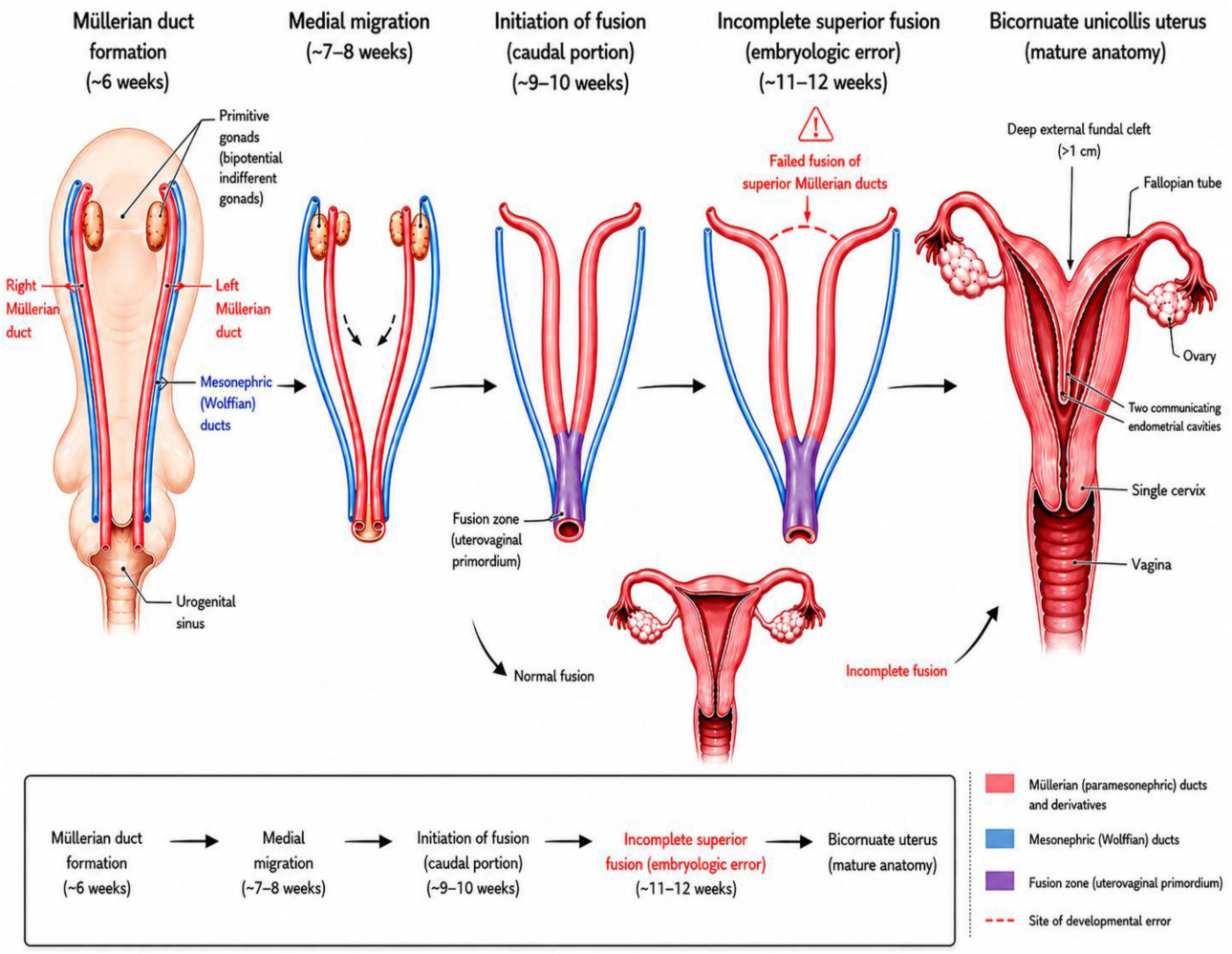

Figure 2 Schematic illustration of normal Müllerian duct development and the embryological defect leading to a bicornuate uterus. Sequential diagrams demonstrate Müllerian duct formation, fusion, and septal resorption, followed by incomplete ductal fusion resulting in bicornuate unicollis uterine anomaly.

bicornuate uterus in women presenting with infertility, recurrent miscarriage, preterm birth, or obstetric complications before achieving a viable birth.[12,15,16] In contrast, our patient initially demonstrated apparently normal reproductive capacity, which may have reduced clinical suspicion for an underlying congenital uterine anomaly. This unusual sequence of events highlights an important clinical lesson: a previous successful pregnancy does not exclude the presence of a significant structural uterine abnormality. Similar observations have been reported sporadically in the literature, where congenital uterine anomalies remained undiagnosed until adverse outcomes occurred in subsequent pregnancies.[14,26,27] However, reports documenting secondary recurrent pregnancy loss following a prior uncomplicated term delivery remain relatively uncommon, particularly from low-resource settings, making this case a valuable addition to the existing body of evidence.

A plausible histological explanation for this clinical paradox relates to regional variation in endometrial and myometrial quality within the malformed uterus. The initial successful term pregnancy may have resulted from implantation within a well-vascularized portion of the uterine horn with adequate endometrial receptivity and myometrial distensibility, whereas the subsequent first-trimester losses may have occurred following implantation closer to the fibrotic, poorly vascularized fundal cleft separating the two horns, an area characterized by reduced myometrial compliance and impaired placental development. This hypothesis, although not histologically confirmed in the present case, is consistent with proposed mechanisms of pregnancy loss in bicornuate uterus and may help explain why reproductive outcomes can vary markedly between pregnancies in the same patient.

Accurate differentiation of bicornuate uterus from other Müllerian anomalies, particularly septate uterus, is critical because management strategies and reproductive prognoses differ substantially.[9,10,18,19] Contemporary guidelines recommend three-dimensional transvaginal ultrasonography and magnetic resonance imaging as the most reliable diagnostic modalities because they provide detailed assessment of both the uterine cavity and external fundal contour.[2,9–11] In many low-income settings, however, these technologies remain inaccessible, forcing clinicians to rely on conventional two-dimensional ultrasonography and clinical judgment.[19] The present case exemplifies the diagnostic challenges encountered in such environments. Despite experiencing recurrent pregnancy loss, definitive characterization of the anomaly was constrained by limited imaging resources, a situation commonly encountered across many parts of Sub-Saharan Africa. Consequently, congenital uterine anomalies may remain underdiagnosed or be identified only after repeated adverse reproductive events. This diagnostic gap underscores the need for improved access to advanced gynecologic imaging and greater awareness of uterine anomalies among healthcare providers managing women with recurrent pregnancy loss.

The management of bicornuate uterus remains individualized, with surgical correction generally reserved for women with poor reproductive outcomes attributable to the anomaly.[3,5,7,24] Historically, open Strassman metroplasty has been the standard surgical approach and has been associated with improved reproductive outcomes through the creation of a unified uterine cavity capable of supporting implantation and fetal development. The key steps of this technique are illustrated in Figure 3, comprising the transverse fundal incision, opening of the two divergent uterine horns, excision of the intervening myometrial septum, and layered reconstruction of a single, unified uterine cavity.[4,18,23] Several studies have reported substantial reductions in miscarriage rates and improved live birth rates following metroplasty in appropriately selected patients.[1,12,26] This evidence, however, derives largely from small retrospective case series and observational studies with heterogeneous patient selection criteria, and no randomized controlled trials have established the efficacy of metroplasty for recurrent pregnancy loss; consequently, the indications for surgery, including the minimum number of losses that justifies intervention, remain a matter of individualized clinical judgment rather than firm evidence-based consensus.

More recently, laparoscopic metroplasty has emerged as the preferred approach in specialized centers because it offers the advantages of reduced intraoperative blood loss, shorter hospital stay, faster recovery, and a lower risk of postoperative adhesions while achieving comparable reproductive outcomes.[4,7,9,18] However, the successful implementation of minimally invasive reproductive surgery requires specialized equipment, advanced laparoscopic expertise, and adequate perioperative support systems, resources that remain unavailable in many low- and middle-income settings.[4,9] In the present case, an open surgical intervention was considered justified given the patient's history of

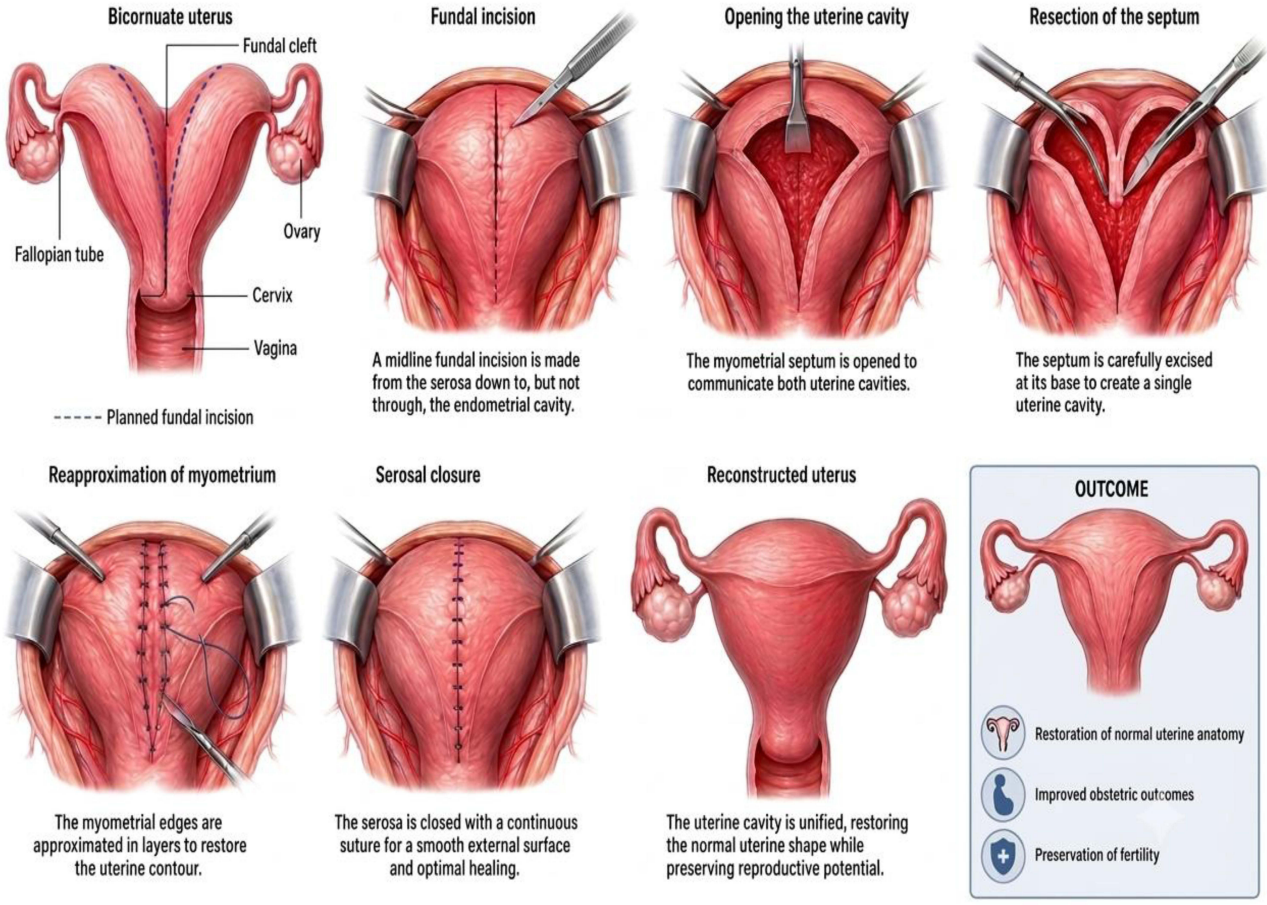

Figure 3 Stepwise illustration of the open Strassman metroplasty for correction of a bicornuate uterus. Sequential panels depict fundal incision, unification of theendometrial cavities, multilayer uterine reconstruction, and restoration of a single uterine cavity.

recurrent pregnancy loss, strong desire for future fertility, and lack of laparoscopic services and expertise within our resource-constrained setting.

The successful completion of open metroplasty in a resource-limited regional referral hospital further demonstrates that complex reproductive reconstructive procedures can be performed safely outside highly specialized centers when adequate surgical expertise is available. Equally important was the comprehensive postoperative counseling provided to the patient and her partner regarding future fertility, timing of conception, contraception during uterine healing, and the need for specialized obstetric surveillance in subsequent pregnancies. This holistic approach is particularly relevant in settings where misconceptions surrounding congenital reproductive disorders may contribute to anxiety and delayed healthcare seeking, a common problem in many parts of Sub-Saharan Africa.

Myometrial healing following Strassman metroplasty is also relevant to counseling for future pregnancies. Because the fundal incision transects the full thickness of the myometrium, adequate time for myometrial regeneration and scar maturation is required before conception is attempted, and the resulting fundal scar carries a recognized risk of uterine rupture during labor.[4] For this reason, elective cesarean delivery prior to the onset of labor is generally recommended for subsequent pregnancies following Strassman metroplasty, and this recommendation was incorporated into the counseling provided to this patient and her partner.[4,7]

The novelty of this case lies in the unusual presentation of a bicornuate uterus with an initial successful term pregnancy followed by secondary recurrent miscarriage, the delayed diagnosis resulting from limited diagnostic resources, and the successful surgical management undertaken in a resource-constrained environment. Few reports from Sub-Saharan Africa have documented this distinctive reproductive trajectory together with the practical challenges

associated with diagnosis and treatment. Nonetheless, several limitations should be acknowledged. The diagnosis was based primarily on conventional ultrasonography and intraoperative findings because advanced imaging modalities such as three-dimensional ultrasonography and magnetic resonance imaging were unavailable. In addition, the evaluation of the patient's recurrent pregnancy losses was incomplete, as antiphospholipid antibody screening and parental or fetal karyotyping were not performed; consequently, a definitive causal role for the bicornuate uterus in this patient's pregnancy losses cannot be established, and the observed association should be interpreted with caution. Furthermore, postoperative follow-up was limited to 2 months, precluding assessment of long-term reproductive outcomes, including subsequent conception, pregnancy progression, and live birth; because reproductive outcomes following surgery have not yet been observed, any inference regarding the reproductive benefit of Strassman metroplasty in this patient remains premature, and only the technical success of the surgical reconstruction can currently be reported. Despite these limitations, this case provides valuable clinical insights into the recognition and management of congenital uterine anomalies in low-resource settings and emphasizes the importance of considering structural uterine abnormalities in women presenting with recurrent pregnancy loss, even when a previous term pregnancy has been achieved.

Conclusion

This case highlights the complex and often overlooked relationship between congenital uterine anomalies and adverse reproductive outcomes, demonstrating that a bicornuate uterus may remain clinically silent despite a previous successful term pregnancy and only become apparent following subsequent pregnancy losses. The delayed diagnosis in this patient underscores the significant challenges faced in resource-limited settings, where access to advanced imaging modalities required for accurate characterization of Müllerian anomalies is often restricted. Technically successful surgical reconstruction through Strassman metroplasty restored a unified uterine cavity and may provide an opportunity to optimize future reproductive outcomes; however, in the absence of longer-term follow-up and a complete recurrent pregnancy loss work-up, any reproductive benefit remains speculative and cannot yet be confirmed. For clinicians practicing in similar low-resource environments, this case emphasizes the importance of maintaining a high index of suspicion for structural uterine abnormalities in women presenting with recurrent pregnancy loss, regardless of prior favorable obstetric outcomes. Early recognition, timely referral for appropriate imaging and specialist evaluation, comprehensive patient counseling, and individualized management are essential to improving reproductive care and reducing preventable pregnancy losses associated with congenital uterine anomalies.

Data Sharing Statement

All data generated or analyzed during this case report are included in the published article.

Ethics Approval and Consent to Participate

Ethical approval was not required for this case report in accordance with the local institutional policy. A written informed consent was, however, obtained from the patient for the publication of this case report.

Consent for Publication

A written informed consent was obtained from the patient for publication of this case report and any accompanying data such as pictures and laboratory results.

Acknowledgments

We would like to extend our sincere appreciation to the patient for her trust, cooperation, and willingness to share her experience. We are especially grateful for her provision of informed consent for the publication of this case report, which we hope will enhance awareness of bicornuate uterus and other congenital reproductive anomalies and contribute to improved patient care in similar resource-constrained settings. We are also very grateful to the Departments of Obstetrics and Gynecology of Kabale University School of Medicine and Kabale Regional Referral Hospital for their participation in the care of this patient and writing of this case report.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising, or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

The authors declare that they have no competing interests in this work.

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