

Vaginal Deliveries in Vaginal Abnormalities

Dr. G.P.N. Karunavathi¹ Dr. V. Revathi²

^{1,2}(Department Of Obgy, Siddhartha Medical College/ Dr.Ntruhs, India)

Abstract: Here are the two cases reported with the vaginal abnormalities and delivered normally. After delivery surgical repair of vaginal septum done under general anaesthesia. After 6 weeks of delivery, they were followed at Gynaec Clinic and they were subjected to imaging techniques i.e., 3D U/S, HSG & Hysteroscopy. No associated uterine anomalies detected. Both the mother & the baby were doing well. The management of the cases is discussed.

Keywords: Longitudinal vaginal septum, Mullerian duct, transverse vaginal septum. Vaginal abnormality & vaginal delivery.

I. Introduction

Vaginal abnormalities are of the different types development of mullerian duct at any time between their origin from the coelomic epithelium at 5weeks of embryonic age. The vagina delops partly from the mullerian duct and partly from the urogenital sinus. The lumen of the lower vagina is then formed via apoptosis of the central cells

In this vaginal plate, extending in a cephalic direction. Complete canalization occurs by 20weeks of intrauterine life. On the other hand the mullerian duct fuse together between the 11th & 13th week of intrauterine life. With this fusion and subsequent absorption occurring in a caudal cranial direction. One of these abnormalities is transverse vaginal septum a vertical fusion disorder between the mullerian ducts and urogenital sinus, which has been linked to autosomal recessive transmission. Longitudinal vaginal septum is typically associated with uterine anomalies such as a septate uterus or uterus didelphys, the septum may be complete or partial. In recent decades the incidence of vaginal septum reported is 0.001 to 10% and woman progressed upto term are very rare.

II. Case Report

A 20 year old Mrs. ABC primigravida who is an unbooked & unregistered case till now. Admitted in labour room on 15th oct,2014 with C/o labour pains. There was no significant positive personal, past & family history. No previous ultrasound reports. On general examination she was well built & well nourished. Her vitals were normal. Gestational age corresponded to 36weeks, fetus in cephalic presentation, fetal heart rate : 138 per minute, uterus acting 4contractions of 45seconds each in 10minutes.

On per vaginal examination a longitudinal vaginal septum felt from 12^o to 6^o clock position. On the left of the vaginal septum cervical rim was felt, cervix was fully effaced, 8 to 9cms dilated with vertex as the presenting part at 0 station. Membranes were absent & pelvis was adequate.

With mere care she delivered normally with a single live male baby 2.6kgs and there was an elastic structure about 7cms, hanging from the posterior vaginal wall. It was avascular, non-tender, no active bleeding from the flap. Then patient was examined under general anaesthesia, the anterior end of septum was torn. Posterior end was intact (Fig 1). Excision of septum done (Fig 2), anterior & posterior vaginal wall of sutured. Haemostasis is secured. No cervical tear & episiotomy was sutured. Both the mother & child were doing well.

A 22 year old primigravida Mrs. XYZ, the second case was admitted in labour room on Nov, 20th 2014 with complaints of labour pains. She was unregistered & unbooked till now. On examination we found the general condition was good. On abdominal examination gravid uterus of term gestation with cephalic presentation fetal heart rate of 128 per minute, uterus was contracting 3 contractions of the 45seconds each in 10minutes. On per vaginal examination there was a transverse vaginal septum in lower vagina. Cervix was fully effaced & 8cms dilated & she delivered spontaneously within ½ an hour with excessive vaginal tears. She delivered a single live female baby of 2.2kgs baby is active and healthy. After surgical repair of transverse vaginal septum (Fig 3) tears and episiotomy under general anaesthesia. Both the mother & baby were doing well. Both patients were followed at gynaec OP after 6weeks of delivery & subjected to 3D ultrasound, HSG, Hysteroscopy. No associated uterine anomalies were detected.

III. Discussion

The American fertility society classified the mullerian anomalies. There may be Agenesis, Unicornuate uterus (20%), Uterus didelphys(57%), Bicornuate unicollis (10%), Septate uterus (55%), Arcuate uterus. Each of these may not be associated with vaginal septum⁽²⁾. The incidence of mullerian duct anomalies is 0.001-10%.

Although vaginal abnormalities are rare. Taken into consideration differential diagnosis of cases of dyspareunia, cyclic pelvic pain, haemocolpos, hematometra. Diagnosis & treatment in time. The principal tools for diagnosis of longitudinal and transverse vaginal septum are 3D U/S, HSG, hysteroscopy, MRI [1, 2].

Longitudinal vaginal septum is complete and high partial [5]. Associated uterine malformations are frequent. And the septum is asymptomatic in most of the cases. In some cases it may lead to fertility problem, abortion, preterm delivery & dystocia leading to C-Section [5]. In transverse vaginal septum head is visible through cut in septum or cut through septum occur while delivery [4].

We can allow trial of labour in both longitudinal and transverse vaginal septum [1, 3].

IV. 4. Figures



Fig 1 intact post. End of long septum

Fig 2 excision of septum

Fig 3 repair of transverse septum

V. Conclusion

Even though vaginal abnormalities are rare as they allow to progress till term & can be allowed trial of labour. The transverse vaginal septum is associated with few urologic or other anomalies. A septum may be thick enough to obstruct the labour & can still cause dystocia during labour. Spontaneous abortions was so high, there may be associated congenital anomalies include urinary tract anomalies, coarctation of the aorta and malformation of the lumbar spine.

Vaginal patency & coital function are successfully established in so many cases. Incidence of endometriosis was high. If such cases are booked earlier in antenatal OP the management of the choice would be the early decision for the abdominal delivery, double setup delivery in the operation theatre, preparation of the patient for the surgical repair of septum etc.

References

- [1]. Antoni Henriques de Franca Neto Bianca, "Intrapartum diagnosis and treatment of longitudinal vaginal septum" case reports in obstetrics and gynaecology vol 2014.
- [2]. Peeti Nisture, Niranjana Chavan, "Vaginal delivery in a case of longitudinal vaginal septum – an interesting case report" Bombay hospital journal, vol 51, no 2, 2009.
- [3]. Blanton EN, Rouse DJ, "Trial of labor in women with transverse vaginal septum". *Obstet Gynaecol*, 101, (5 pt 2) 2003.
- [4]. Yusuf Ustun, Yaprak Engin Ustun, "A case of transverse vaginal septum diagnosed during labor"
- [5]. B Haddad, C Louis, "Longitudinal vaginal septum a retrospective study of 202 cases" *European journal of obstetrics and gynaecology and reproductive biology* vol 74 pp 197-199, 1997.