Case Report

A rare case of transverse vaginal septum

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Abstract

Transverse vaginal septum is a rare condition that results from incomplete fusion between the vaginal components of the mullerian ducts and the urogenital sinus. A patient presented with the complaint of aparunia. A pediatric Foley was inserted through a micro-fenestration in the septum. Distended bulb of pediatric Foley catheters used to safeguard inadvertent trauma to nearby structures and proper localization of septal thickness.

KEY WORDS: Transverse vaginal septum, vapareunia, rare case

Introduction

Transverse vaginal septum is a rare condition that results from incomplete fusion between the vaginal components of the mullerian ducts and the urogenital sinus. Its incidence is approximately 1 in 30,000 to 1 in 80,000 women (Figure 1). These septa may be located at various levels in the vagina although most are found in the upper and midvagina and thicker septa are closer to cervix.[1] Renal, cardiac, and musculoskeletal anomalies are rarely seen with transverse vaginal septa.[2] The septa are usually less than 1 cm in thickness and may have small central or eccentric perforation. A case was presented with transverse vaginal septum presenting with complaint of apareunia.

Case Report

A 22-year-old recently married women presented with complaint of apareunia. She attained menarche at 15 years of age and had regular menstrual cycles. On examination she had normal secondary sex characters. Local examination revealed normal vulva, introitus, and normal opening of urethra. There was no vagina instead there was intervening soft tissue between urethra and rectum suggestive of vaginal septum. The septum presented a microfenestration in center. Pervaginal examination was not possible. However on per rectal examination uterus was felt. Ultrasound revealed normal uterus and ovaries. A diagnosis of transverse septum of the vagina situated distal to the cervix was made.

Patient was operated under spinal anesthesia in dorsal lithotomy position. The perineum was painted and drapped. Urinary bladder was catheterised to safeguard bladder. Through the micro-fenestration of vaginal septum, a pediatric Foleys were inserted between cervix above and vaginal septum below and bulb distended with NS. Figure 2 shows the placement of pediatric Foleys. Traction was applied on catheter to know thickness of the septum and help in bulging of the septum exteriorly. Guided by catheter 5–6 radial incisions were given in septum with sharp edge of knife keeping away from bulb of catheter. These individual flaps of vaginal septum were caught with allis forceps and excised from vagina. Foley catheters were expelled out itself. Cut edges of vaginal mucosa above and below the septum were approximated with interrupted 3-0 vicryl .Urethral catheter was removed after 6 h. A vaginal mould was placed in situ for 7 days. She had normal postoperative period. After 1 month of follow-up she is had no complications and vaginal wound had healed well. Now she is 6 months pregnant.

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Discussion

Transverse vaginal septum occurs due to failed resorption of the tissues of embryologic components of vagina between urogenital sinus and fused mullerian ducts. It may be perforated (incomplete) or imperforated (complete). Majority may have a small hole called fenestration in the septum as was in our case. Complete septum presents with symptoms of vaginal obstruction which occurs at the time of menarche since

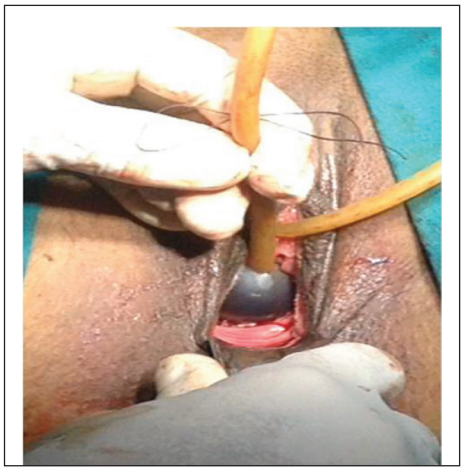

Figure 1: Transverse vaginal septum.

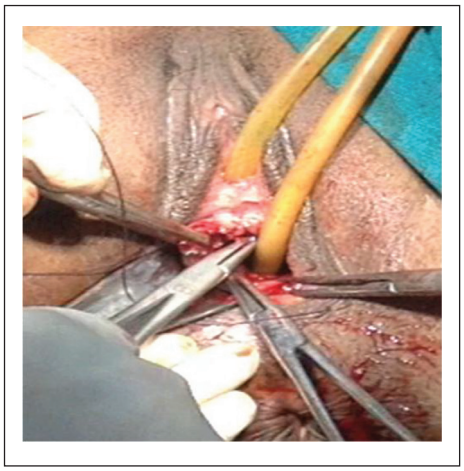

Figure 2: Placement of pediatric Foleys.

menstrual blood gets entrapped above the septum. It results in primary amenorrhea, cryptomenorrhea, cyclic pelvic pain, dysmenorrhoea apareunia, and dyspareunia. An incomplete septum which allows vaginal secretions and menstrual blood flow from vagina and hence is asymptomatic, does not require correction during childhood or adolescence. It requires surgical excision of fibrous tissue when patient complaints of infertility or dyspareunia[3] as was in our case. Careful clinical examination and ultrasound are usually sufficient for diagnosis. MRI is needed in unclear cases like thick and high transverse vaginal septum. A small septum can be resected followed by end to end anastomosis of upper and lower vaginal mucosa. A thick septum is more difficult to excise and repair. It requires extensive dissection between bladder and rectum. Sometimes even exploratory laprotomy may be needed to guide a probe through the uterine fundus and cervix and to assist in locating a high hematocolpos. Dilation techniques can be used in lieu of surgery, before surgery in order to improve outcomes and after surgery to prevent strictures, scarring or stenosis of the surgical site.[2] A Z plasty can be used to prevent circumferential scar formation. The Olbert balloon technique has also been described to maximize the vaginal mucosa available for anastomosis and avoid postoperative narrowing of vagina.[4] Great care should be taken to avoid injury to bladder, rectum, and cervix. In our case distended bulb of a pediatric Foley catheters were a safeguard against inadvertent trauma to nearby structures and proper localisation of septal thickness.

Conclusion

Transverse vaginal septum is a rare mullerian anomaly. All physicians should be aware of this entity in differential diagnosis of hematocolpos, abdominal pain and primary amenorrhea in early adolescent years. Incomplete septum presents mainly with either infertility or dyspareunia. Early diagnosis prevents complications of endometriosis and infertility.[1] Strict follow-up should be emphasized because it carries a high risk of reocclusion leading to recurrence of symptoms.

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