

A CASE OF TRANSVERSE VAGINAL SEPTUM DIAGNOSED DURING LABOR Doğum eylemi sırasında tanı almış bir transvers vajinal septum olgusu

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Abstract : Transverse vaginal septum is the result of faulty canalization of the embryonic vagina. We described a case of transverse vaginal septum with a small central aperture diagnosed during labor. An 18-years-old girl at 28 weeks of gestation presented to our obstetric department complaining of symptoms of preterm delivery. Pelvic and vaginal ultrasonography, with gynecologic examination established a diagnosis of transverse vaginal septum in mid-vagina. An incision in the vaginal septum allowed us to see the head of the fetus in the vagina. The diagnosis of transverse vaginal septum was confirmed during labor and excision of the septum prevented the uterine rupture.

Key Words: Vagina; labor, obstetric; Mullerian ducts.

Özet : Transvers vajinal septum embriyonik vajinanın hatalı kanalizasyonu sonucu ortaya çıkmaktadır. Doğum sırasında tanısı konulan küçük bir orifise sahip transvers vajinal septum olgusu tanımlanmıştır. On sekiz yaşında, 28 haftalık gebeliğe sahip olgu kliniğimize preterm eylem bulgularıyla başvurmuş, yapılan pelvik muayene ve ultrasonografi ile mid-vajinadaki transvers septum tanısı konmuştur. Bu septum insize edildiğinde fetal başın vajende olduğu izlenmiştir. Eylemdeki bir hastada (Septumun)tanısının konması ve eksizye edilmesi uterus rüptürünü önlemiştir.

Anahtar Kelimeler: Vajen; doğum; Müller kanalı.

Transverse vaginal septum is the result of defective canalization of the embryonic vagina. These septa may be without an opening (complete or obstructed) or may have a small central aperture (incomplete or non-obstructed). They are usually found in the mid-vagina but may occur at any level [1]. The estimated incidence is 1 per 30,000 to 84,000 women [2].

We described a case of transverse vaginal septum with a small central aperture diagnosed during labor.

The diagnosis of the transverse vaginal septum was confirmed during labor and excision of the septum prevented the uterine rupture.

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CASE

An 18-year-old nullipara at 28 weeks of gestation presented to our obstetric department complaining of symptoms of preterm delivery. In spite of contractions with high amplitude in the tocography, a shortened vagina was found, although the cervix was not clearly defined. A congenital obstructive vaginal membrane with a tiny opening was detected in the vaginal examination (Figure 1). Ultrasound revealed 28 weeks of gestation and a fully dilated cervix behind a transverse vaginal septum. Pelvic and vaginal ultrasonography, with gynecologic examination established a diagnosis of transverse vaginal septum in mid-vagina. Epidural analgesia was performed and an incision in the vaginal septum allowed us to see the head of the fetus in the vagina (Figure 2). After a few minutes a 1,480-g infant was spontaneously delivered.

The postpartum course of the patient was uneventful and she had fully recovered after six weeks follow-up.

DISCUSSION

The case of an unusual presentation of Mullerian anomaly is described in this paper. Transverse vaginal septum is a rare diagnosis to make during labor and important to treat before uterine rupture.

A transverse vaginal septum can develop at any location in the vagina but is more common in the mid-vagina, as in our case. This defect presumably is caused by failure of absorption of the tissue that separates the two, or by failure of complete fusion of the two embryologic components of the vagina (1).

A complete septum usually presents after menarche with progressive abdominal pain during menses secondary to hematocolpos, similar to signs and symptoms of an imperforate hymen. Therefore, the diagnosis of a transverse vaginal septum is often delayed until after menarche, when menstrual blood is trapped behind an obstructing membrane (3). Ahmed et al (4) described a 12-year-old girl with distal mucocolpos and proximal hematocolpos secondary to concurrent imperforate hymen and transverse vaginal septum.

An incomplete septum is usually asymptomatic, and therefore does not require correction during childhood or early adolescence. The central aperture allows for vaginal secretions and menstrual flow from the vagina. Transverse vaginal septum during pregnancy may lead to significant vaginal lacerations or to a cesarean delivery. Surgical correction should follow an attempt to identify the extent of the lesion. Blanton described the management and outcomes of two gravidas with transverse vaginal septa first diagnosed during pregnancy (5).

Such a stricture is occasionally mistaken for the upper limit of the vaginal vault, and at the time of labor, the opening in the septum is erroneously considered to be an undilated external os. After the external os has dilated completely, the head impinges upon the septum and causes it to bulge downward. If the septum does

not yield, slight pressure upon its opening will usually lead to further dilatation, but occasionally cruciate incisions may be required to permit delivery, as in our case.

A high index of suspicion is necessary to diagnose this type of disorder. Gynecologists should be aware of the possibility of transverse vaginal septum in women in labor who become pregnant from a small central aperture.

The diagnosis of the transverse vaginal septum was confirmed during labor and excision of the septum prevented uterine rupture.



Figure 1: Transverse vaginal septum



Figure 2: Head of the fetus in the vagina

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