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Case Report

Vaginal delivery in a case of Longitudinal Vaginal Septum: A Case report

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Abstract

Uterine didelphys with longitudinal vaginal septum is a rare mullerian defect presenting with a host of obstetric complications like miscarriages, preterm labour, malpresentations, fetal growth restriction, labor dystocia and obstructed labor. The incidence of uterine didelphys has been reported as 01-0.5% to 3.2% in different studies. It is not clear whether caesarean section or vaginal deliveries are the reference mode of delivery. We present a case report of a patient with uterine didelphys with longitudinal vaginal septum who delivered vaginally a healthy male baby of 1.63 kg at 32 weeks period of gestation.

Key words: longitudinal vaginal septum, uterine didelphys, vaginal delivery.

Introduction

Longitudinal vaginal septum is a rare mullerian defect. It can present with dyspareunia, infertility or obstetric complications like abnormal presentations, preterm labour and dystocia of labour. The preferred mode of delivery is still unclear. We present a case of longitudinal vaginal septum who delivered vaginally.

Case History

A 22 year old primigravida presented to gynaecology emergency room with 8 months amenorrhea and labour pains. She was married for 18 months and gave a history of dyspareunia. However, she conceived spontaneously. At the time of admission, she was in 32 weeks of gestation and had , history of labour pains and leaking per vaginum for past 8 hours. Her BP was normal. On per abdominal examination, uterus was corresponding to period of gestation, with breech presentation. The clinically estimated fetal weight was 1.5 kg - 1.8 kg and fetal heart sounds was 140 beats/min and regular. She was having good uterine contractions. On local examination, there was a longitudinal vaginal septum. On per speculum examination, a 2-3 cms thick longitudinal septum was seen running in from 12'o clock to 6'o clock position, occupying lower half of vagina. On per vaginum examination, cervix was fully dilated, fully effaced and an extended breech was lying at +2 station, membranes were absent and pelvis was found to be adequate. Decision for vaginal delivery was taken. The septum was clamped and cut. The urethra and bladder were away. The cut ends were ligated. Patient delivered as assisted breech delivery. A healthy male baby of birth weight 1.63 kg, with an apgar score of 9,9,9. Vaginal exploration revealed a small cervical tear at 9'o clock position and sutured. The other cervix was not visualized at this time, as it was pulled up. The cut ends of vaginal septum were not bleeding and there was no vaginal laceration. Patient was discharged after 48 hours of birth. Patient was examined after eight weeks of birth. Two cervices were seen. The vaginal cavity was single, the ends of septum had well healed. Two uteri with two cervices visualized under Ultrasonography.

Discussion

The failure of fusion of the two mullerian ducts results in duplication of mullerian structures; a didelphic uterus has two uteri, two endometrial cavities,

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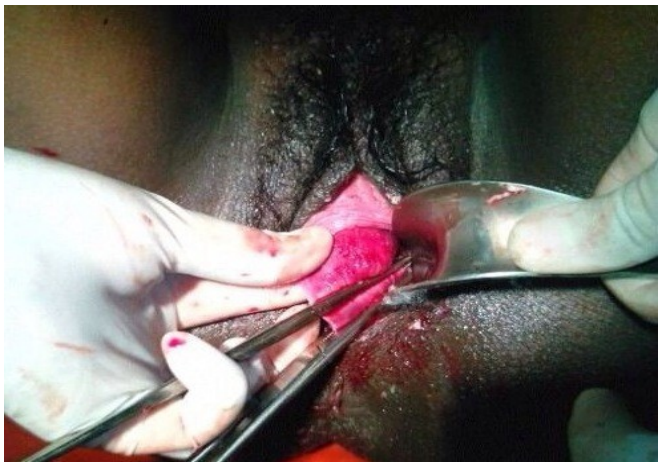

Figure 1: Showing the longitudinal vaginal septum; two clamps are seen applied on the septum, between which the resection was done.

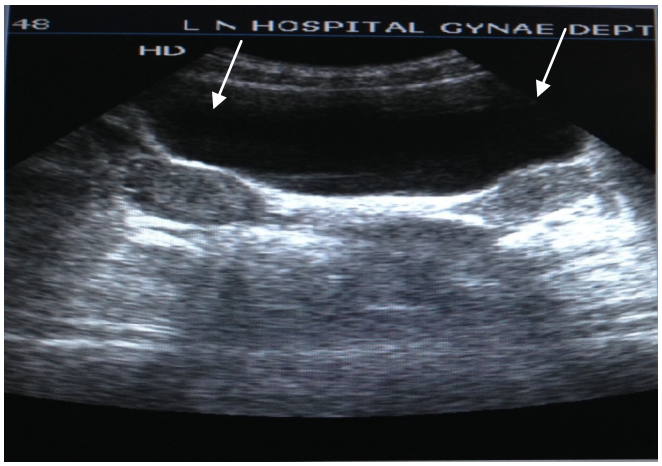

Figure 2: Ultrasound picture showing presence of two uteri.

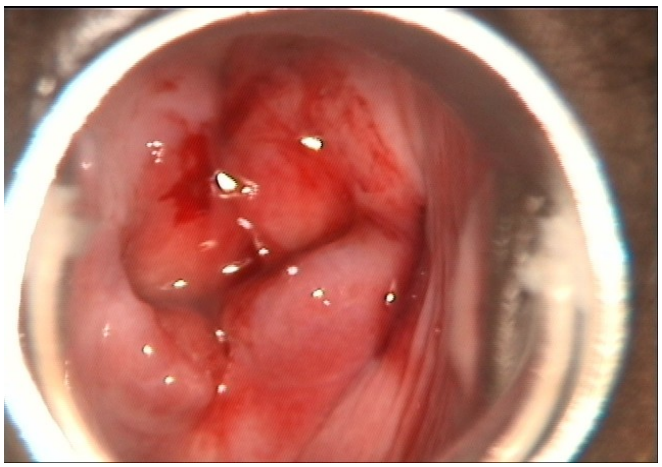

Figure 3: picture showing presence of two cervices. Note made of single vagina, the margins of resection completely healed. The picture was taken after 8 weeks of birth.

and two cervices. A longitudinal vaginal septum is present in 75% of cases [1]. The true prevalence is unknown because the anomaly may not manifest until the reproductive years. It has been reported as 01-0.5% to 3.2% in different studies [2,3]. Rackow and associates reported an incidence of 3–4% in fertile and infertile women, 5–10% in women with early recurrent pregnancy loss (RPL), and up to 25% in women with late first and second trimester pregnancy loss or preterm delivery [3].

The presentation of this condition is varied. It may remain asymptomatic for many years and may be incidentally discovered in otherwise healthy women or in women undergoing evaluation for infertility [4]. Patients may have menorrhagia (due to increased surface area of two endometrial cavities), dysmenorrhea and pelvic pain. Patients may complain of difficulty in inserting a tampon or bleeding during menstruation with a tampon. Dyspareunia may be a presenting symptom and sometimes, the only complaint.

There are increased chances of miscarriages, preterm labour, malpresentations and fetal growth restriction. A study reported a pooled spontaneous abortion rate of 32.2%, a preterm birth rate of 28.3%, a term delivery rate of 36.2%, and a live birth rate of 55.9%[5]. During labour, there are high chances of dystocia and obstructed labour [3].

The incidence of cesarean section in patients with uterine didelphys is reported to be 82% in a study [6]. Although, the chances of soft tissue dystocia and obstructed labour are high, vaginal deliveries have been attempted and reported. Vaginal delivery is not contraindicated in uterine didelphys with longitudinal vaginal septum. The final decision regarding mode of delivery: Cesarean section versus Vaginal delivery should be individualized. Some of these patients can deliver vaginally, though it requires intensive maternal and fetal surveillance. Resection of the septum can also be done in second trimester protecting the bladder, urethra and rectum. Resection can also be done during labour, which can facilitate normal vaginal delivery. Although, close watch should be kept on progress of labour.

Conclusion

Longitudinal septum in the lower vagina is not an absolute indication for cesarean section. Vaginal delivery can be allowed in cases who present in labour after excision of the vaginal septum.

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