

Case Report: Addressing Potential Challenges in Postoperative Management of Transverse Vaginal Septum

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Introduction

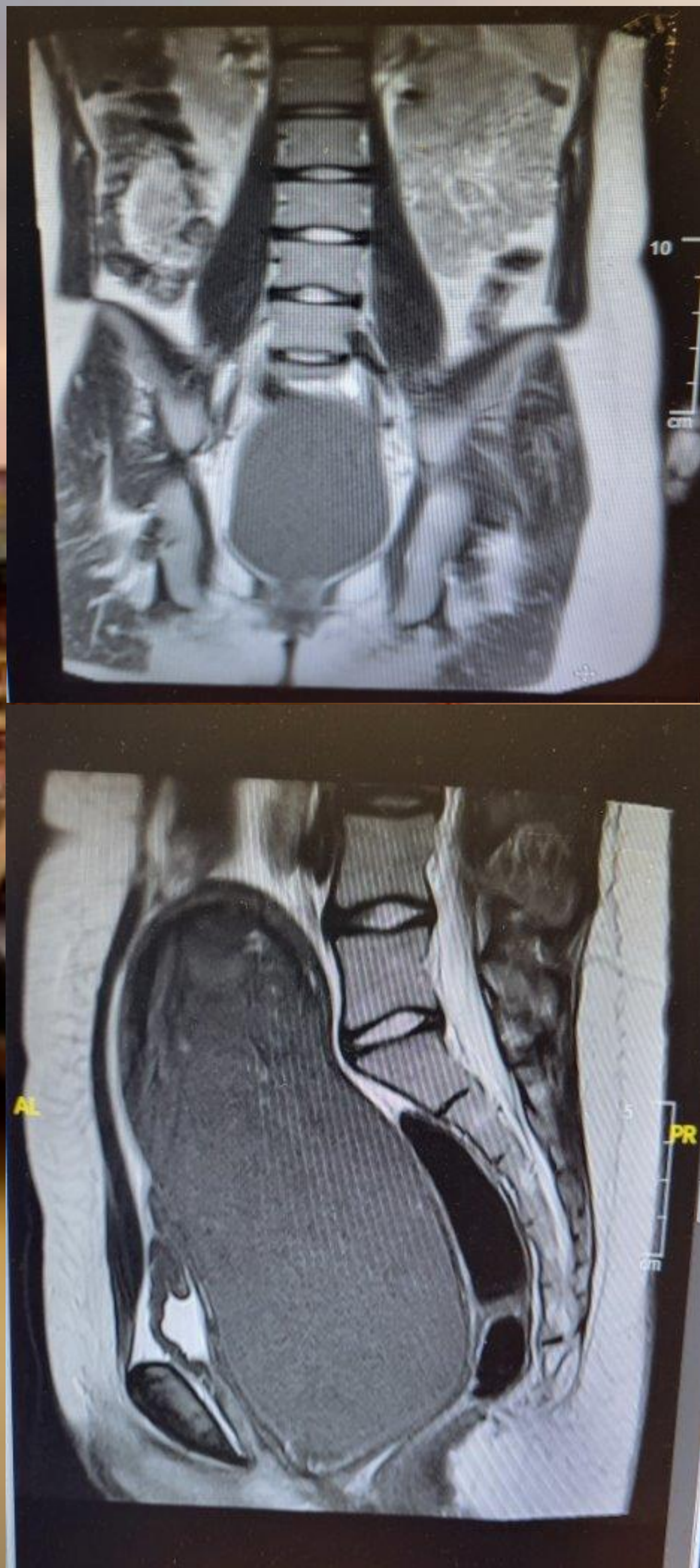
Transverse vaginal septum(TVS) is a rare Mullerian anamoly with incidence 1/2100-1/7200. Variability in the position, thickness, and orientation of TVS poses diagnostic and management challenges.

Case Report

16-year-old, BMI 23, seen with mum, referred to PAG services with primary amenorrhea, lower abdominal pain, inability to perform sexual intercourse. Secondary sexual development appropriate for age. Menarche: none. No androgenic features.

Examination: left-sided mobile tender abdominal lump felt. Perineal examination with consent + chaperone: Transverse vaginal septum.

Investigations: Hormonal profile: normal. MRI pelvis: Vagina grossly distended by blood measuring 20x9x8 cm craniocaudal/axially. The lower border with rounded configuration rather than beaked in keeping with transverse vaginal septum. Normal looking urinary bladder, uterus, ovaries and cervix at top of vagina with normal morphology. Rectum stretched over the distended vagina.



Management

MDT discussion. Septum deemed operable at local Trust. Surgery planned after progesterone suppression to reduce further accumulation of haematocolpos. Examination-under-anesthesia: Haematocolpos palpable up to the umbilicus, patulous urethra, thin transverse septum in vagina, no bulging noted. Catheter inserted to delineate urethra. Cross incision to septum yielded 2 liters of altered blood drained from haematocolpos. Post-op: uneventful.

Review clinic 2/12: Normal periods after initial light bleed but constant watery vaginal discharge.

Ultrasound KUB: Normal
CT-Urogram: Normal (r/o ureterovaginal fistula)
Pelvic USS: Normal uterus/endometrium.

Examination: Vaginal septum healed, no tenderness, admitting one finger with ease for digital exam. Nulliparous cervix felt.

Review 13 months post-op: Continues to leak watery discharge, emptying bladder normally. Normal periods

Now sexually active and with contraceptive Implant. No stress leaks/bleeding during intercourse. Referred to Urology for Cystoscopy that ruled out ureterovesical fistula.

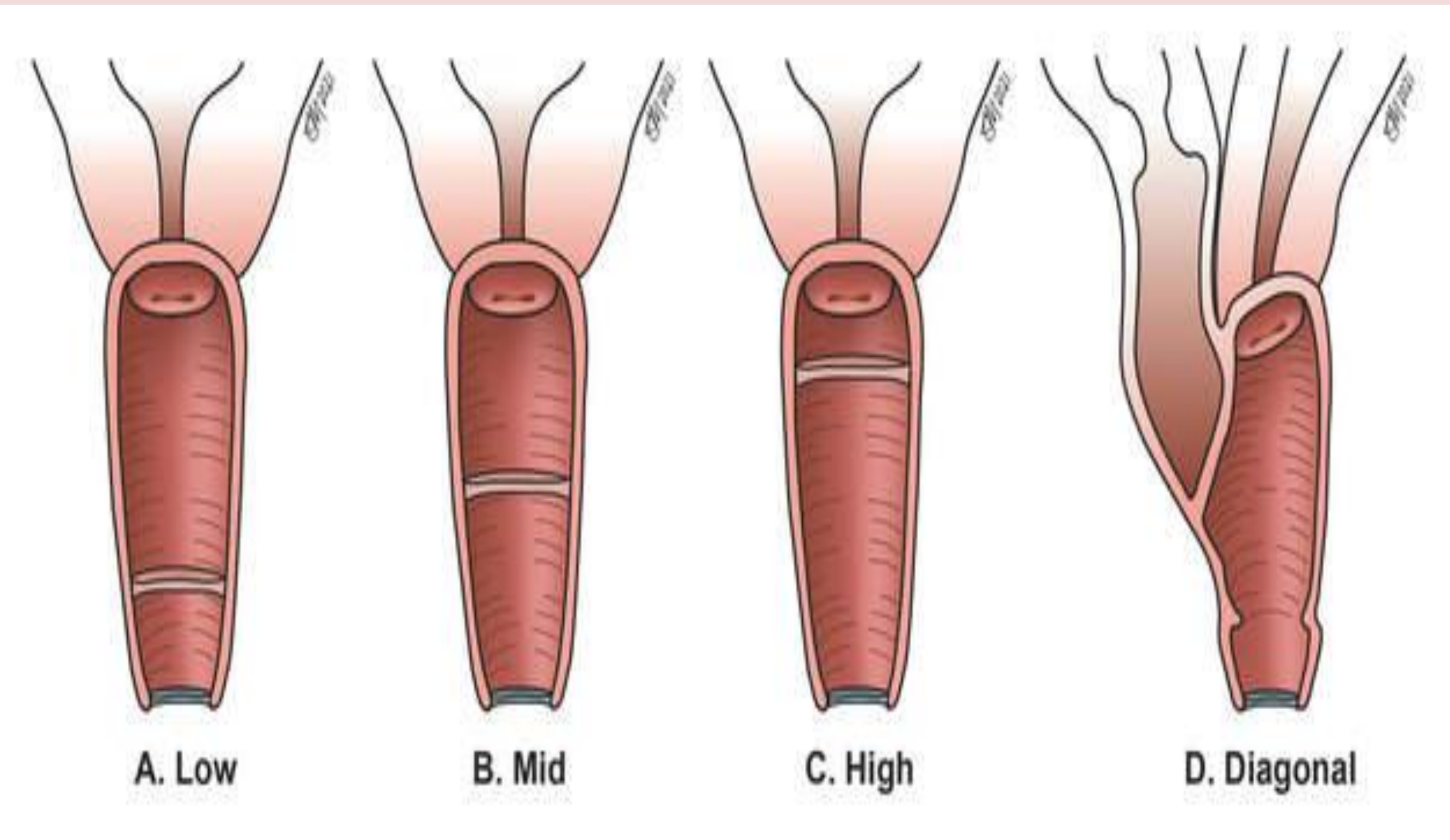
Conclusion

A large meta-analysis of TVS reveals the most common management was simple vaginal excision. Further prospective studies are needed to guide surgical planning. Favourable factors include management in a tertiary center and patient compliance with vaginal dilation. Accurate assessment of the septum and investigating associated genitourinary and gastrointestinal tract anomalies is imperative.

Discussion

TVS can vary from complete occlusion to perforated foramina of 1–5mm diameter.

Accurate assessment, including location in reference to distance from hymen as: **low <3cm (72%), intermediate 3–6cm (22%), or high >6cm (6%), thickness (<1cm or >1cm), and presence of foramina**, is crucial for selecting the appropriate treatment



Ultrasound is used as first-line but MRI is the recommended diagnostic modality for evaluating complex Müllerian duct anomalies, as used in our case with MDT approach pre- and post-procedure.

Vaginal stenosis/re-obstruction, the most common complication, was not reported in our case >18 months post-procedure.

Reference

Transverse Vaginal Septum Resection: Technique, Timing. <https://doi.org/10.1016/j.jpap.2021.09.002>