

CASE REPORT**ASSISTED BREECH DELIVERY WITH TRANSVERSE VAGINAL SEPTUM****Sadia Anwar, Tooba Moon*, Sajjad Ahmad Baloch**, Syed Humayun Shah****

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The incidence of vaginal septum is rare. The infrequency of this anomaly makes accurate estimates of the true incidence very difficult to obtain. Diagnosis is based on careful history and examination. This is the case of a patient who presented with transverse vaginal septum in labour and breech presentation. The septum was resected and the foetus delivered normally. Careful vaginal examination should be performed in pregnant women at term before labour to detect such manageable abnormalities.

CASE REPORT

A 25-year-old primigravida presented to the labour room in Gynaecology Department of Punjab Social Security Hospital Raiwind Lahore with a history of labour pains at home for six to eight hours. The patient had been handled by a local *Dai* who tried home delivery. The patient was in severe discomfort but normotensive and afebrile. Her abdominal examination revealed fundal height at term with longitudinal lie of foetus. Ultrasound was performed which revealed extended breech presentation of foetus, positive foetal cardiac activity and fundal posterior placenta. On pelvic examination, patient was fully dilated with breech sitting at introitus and scrotum of baby was visible. Patient was immediately shifted to delivery room, put in lithotomy position. A transverse vaginal septum was seen stretching over the anus of baby. The patient was pushing but the breech was not delivering due to septum. The septum was held with two small artery forceps and excised in between, an episiotomy was performed followed by assisted breech delivery in a comfortable way. An alive male baby of 2.6 Kg was delivered with good APGAR score. The placenta and membranes were expelled spontaneously. Later on the septum was examined which was located in lower 1/3 of vagina, its margins were trimmed and ligated with catgut No. 1 suture. Haemostasis was secured followed by stitching of episiotomy in routine. The patient's condition was satisfactory and she was discharged on next day.

DISCUSSION

When the vagina does not develop normally, a number of abnormalities have been described.¹ The vagina may be partially mal-developed leading to a vaginal obstruction which may be complete or incomplete.² Vertical fusion defects may result from failure of fusion of Müllerian system with the urogenital sinus or may be due to incomplete canalisation of the vagina. Disorders of lateral fusion are due to the failure of Müllerian ducts to unite and may create a duplicated uterovaginal septum which may be obstructive or non-obstructive.³

**A****B****Figure-1 A and B: Excised vaginal septum before trimming and suturing**

Vertical fusion defects or transverse vaginal septum may present as teenagers with cyclical abdominal pain and therefore cryptomenorrhoea or it may present with associated symptoms of urinary frequency and/or retention.⁴ Disorders of lateral fusion usually present with incidental finding during pregnancy or patient may present with dyspareunia.

The diagnosis is primarily clinical, imaging have a role limited to ultrasound assessment of uterus for the detection of haematometra and haematocolpos and the investigations of urinary tract is pertinent.⁵

The management of such abnormalities is surgical but definitely it requires reassurance and psychological support.⁶ In obstructing transverse vaginal septae, in the lower and middle thirds of vagina, the procedure is extremely simple and surgical removal of septum can almost always be performed transvaginally. Great care must be taken to ensure that excision is adequate, otherwise vaginal stenosis at the site of septum will remain a problem.⁷ When resecting the septum generous pedicles should be taken to ensure haemostasis. The results and outlook for these patients are extremely good.⁸

CONCLUSION

Careful vaginal examination should be performed in pregnant women at term before labour to detect such manageable abnormalities.

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