Transverse Vaginal Septum

Transverse vaginal septum is a congenital condition of females that can block the passage of vaginal secretions causing primary amenorrhea, hematocolpus and cyclic pelvic pain. Different to imperforate hymen, in a transverse vaginal septum you find a rim of nonbulging hymenal tissue on the vestibular floor with an intravaginal bulging membrane. The septum can be found in the upper, middle or lower vagina varying in thickness. Most common location of the septum is the upper vagina. Histologically, the diagnosis of transverse vaginal septum is made due to the presence of müllerian duct (mesodermal origin) tissue in the septum. Transverse vaginal septum is a defect of vertical fusion during embryogenesis of the vagina. The estimated incidence is one per 30,000 to 84,000 women. It is sometimes associated with genitourinary tract, gastrointestinal tract, musculoskeletal, and cardiac malformations. Physical exam and pelvic ultrasound are diagnostic. Surgical resection is the treatment of choice. The mucosa on either side of the blockage should be mobilize for approximation with interrupted sutures, while the underlying fibrous septum should be excised. Postoperative dilation may be necessary to prevent restenosis and dyspareunia. Patients with a complete transverse septum in the middle or upper vagina are less likely to conceive than patients with a septum in the lower vagina. Prompt diagnosis and surgical correction to drain accumulated blood may preserve fertility possibly through the prevention of endometriosis.

References:

Septated Vagina

A septate vagina is another congenital condition that occurs from failure of longitudinal fusion of the lower müllerian ducts leaving a variable amount of an asymptomatic longitudinal vaginal septum in the child. Two vaginal canals are created by the septum completely or partially. As time passes the septate vagina goes unnoticed until the adolescent child start to use tampons or engage in sexual activity. The affected patient
might complain of menstrual leakage with the use of tampons since menstruation will continue to egress from the other vaginal canal not occluded by the tampon. This is the case with complete duplication of the müllerian system. Reassurance and vaginal hygiene is all that is required in these cases. Physical exams including endoscopy along with pelvic ultrasound are diagnostic. The identification of a duplicated cervix and a vaginal septum is consistent with several uterine malformations, which leads to frequent misdiagnosis and errors in management. On the other hand, when the defect is an isolated partial vaginal septum, the patient will complain of dyspareunia during sexual intercourse. Management in these cases consists of excision of the thick septa (septectomy) maintaining good hemostasis.

References:

Direct Inguinal Hernias

Direct inguinal hernias in infants and children are extremely rare comprising less than 2% of all inguinal hernias. Most inguinal hernias in children are of the indirect type where the defect and sac runs along the spermatic cord structures from the internal ring. Direct inguinal hernias occur due to a defect in the transversalis fascia presenting as a bulge medially in the groin. A direct hernia should be suspected when operating for an inguinal hernia and a typical indirect inguinal hernia is not found. Otherwise, most direct inguinal hernias in children are the result of a recurrence after initial repair of an indirect hernia where the inguinal floor was injured during the surgical procedure. During repair of a direct inguinal hernia a defect in the posterior wall of the inguinal canal medial to the epigastric vessels will be identified. The defect is repaired joining the transversalis fascia between the inguinal ligament and the conjoined tendon with interrupted nonabsorbable sutures (Cooper's ligament -McVay- repair). Laparoscopic repair of the common inguinal hernia in the child has reported a higher incidence of direct inguinal hernia.

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