A CASE REPORT OF CERVICO VAGINAL ATRESIA

Roopam Singh
Consultant, Bokaro General Hospital

INTRODUCTION

Development of female genital tract is a complete process dependent upon a series of events, involving cellular differentiation, migration, fusion, and canalization. Failure at any step may result into the congenital anomaly of the genital tract.

Cervical atresia is an uncommon Mullerian anomaly, occurring in 1: 80,000 to 1: 100,000 births (1). It has been shown to be associated with vaginal aplasia in 40 % of cases (2). This case report shows the difficulties faced while managing a case of cervicovaginal atresia.

Case Report

A 14 yrs old girl, presented in emergency with excruciating pain abdomen with a suprapubic lump of 12 to 14 weeks gravid uterus size. Her history revealed that she was experiencing cyclical pain since 6 months which used to subside on taking regular analgesics. The pain went on increasing in subsequent cycles with the appearance of the suprapubic lump.

On examination, she was average built with normal secondary sexual characteristics. Her thyroid and breast were normal with no expressive galactorrhoea. Per abdomen, examination revealed a suprapubic lump of 12 to 14 weeks of gestational size, arising from the pelvis. Her external genitalia were normal with a blind vagina.

Per rectal examination showed a lump, which was 4to 5 cm away from introitus and upper end of which could not be reached.

Ultrasonography showed a cystic mass with thick well defined wall, suggesting of hematometra. Cervical region was not defined. On the left side of haematometra there was another mass suggesting the presence of haemosalpinx. Both the kidneys were normal.

Her Hb% was 12 g. Renal profile was normal.

She was provisionally diagnosed as a case of hematometra and left sided hematosalpinx with blind vagina, under this diagnosis she was planned for formation of neovagina and exploration of cervix for drainage of hematometra from below. For the formation of neovagina help of plastic surgeon was sought for.

During operation a space was created between bladder and rectum and cervix was tried to be explored, which could not be found. So, laparotomy was done and uterus with left tube was found distended with menstrual blood. One incision was given on fundus to remove old collected blood, then internal os was explored with index finger at its supposed site, which was not found. So, one artificial rent was made at the supposed site of cervix and it was opened at the top of newly formed vagina. This rent made patent by stitching the whole thickness with nylone 3-0, at 1, 4, 5 and 7 o’clock position respectively. One foley’s catheter was passed from below and inflated when its bulb was in uterus. A mould was kept in neovagina, after placing skin graft, so that foley’s catheter passes through the hole at the top of mould.

Mould and foley’s catheter were removed as per schedule and she was discharged with a strict follow up schedule. Since 5 years she is under follow up, in which she had occasional episode of dysmenorrhoea and one episode of vaginitis. In June 2015, she got married.

DISCUSSION

Cervico vaginal aplasia is a very rare anomaly, more so, it may be difficult to differentiate it from high transverse vaginal septum and diagnosis may be made during definitive surgery, which happened in our case. So, before
embarking on to definitive surgery, proper diagnosis must be made using advanced diagnostic tools like MRI, if patient’s clinical and financial condition permits, to avoid unnecessary stress during surgery.

Regarding surgery, with advancement in assisted reproduction and laparoscopic surgery, the role of total abdominal hysterectomy is becoming the thing of the past. The recent trend is favoring more conservative approach, preserving reproductive function in form of uterovaginal anastomosis with neovaginal formation. There has been case reports of successful pregnancies following in vitro fertilization with transmyometrial embryo transfer (3). Total hysterectomy is recommended only in failed canalization or when it is not possible (4).

Timing of operation is also a major issue, because delay in anastomosis may cause theoretical risk of endometriosis, at the same time neovagina formation at an early age poses difficulty in dissection because of less amount of tissue at that place.

In non emergency cases, two step process is adopted, with neovagina in 1st step, followed by utero vaginal anastomosis after epithelialization of vagina is complete.

Psychological support in these patients is of utmost importance, because these operations has bearing on their future reproductive life.

CONCLUSION

This rare case has been reported after completing fair enough time in follow up, because there was always a risk of hysterectomy because of occlusion of anastomosis due to ascending infection causing pyometra. More so, difficulties in diagnosing and treating these type of case are real challenge in gynaecological practice, even more if the patient comes in emergency. Because, there is no time left for proper workup or even referring the patient to higher centre for better management.

REFERENCES