Imperforate Hymen Presenting with Regular Menses... A diagnostic dilemma

Geetha V1, Rohini G2

1Assistant Professor, 2Professor & HOD,
Vinayaka Mission’s Kirupananda Variyar Medical College & Hospitals, Salem, Tamilnadu, India.

Abstract
Mullerian anomalies are rare and one among them is uterus didelphys with unilateral imperforate hymen associated with unilateral renal agenesis. A 15-year-old girl presented to our emergency department with urinary retention. On evaluation, she was diagnosed to have uterus didelphys with imperforate hymen on the right side leading to hematocolpos and hematometra on the right side causing urinary retention and also associated with unilateral renal agenesis. Patient was catheterised and urine from bladder drained. Excision of vaginal septum was performed and hematometra drained.

Key words: Uterus didelphys, Hematocolpos, Hematometra, Imperforate hymen, Renal agenesis.

Introduction
Mullerian anomaly varies between 0.1% to 3.8%1. Incidence of uterus didelphys is estimated to be 5%2 and imperforate hymen is 0.1%3. An imperforate hymen is a congenital resorptive defect which does not apparently derive from the Mullerian ducts4. Uterus didelphys with renal agenesis occurs from embryologic arrest at 8 weeks of gestation that simultaneously affects the adjacent Mullerian and metanephric ducts5. Complete obstructing hemivagina with longitudinal vaginal septum may be associated with uterine malformation and ipsilateral renal agenesis6-8. Obstructive anomalies result in retrograde menstruation due to collection of blood in the uterus and the vagina9. Early diagnosis and management of these rare conditions reduce long-term morbidity10,11.

Case Report
A 15-year-old girl presented to our hospital with complaints of abdominal pain and inability to pass urine. Her menarche was 2 years ago with regular menstrual cycles. Her physical and general examination was normal. Abdominal examination revealed a suprapubic mass due to urinary retention. Bladder was catheterised and urine drained. Pelvic examination revealed imperforate hymen (Figure 1). Per rectal examination revealed a tense cystic swelling anteriorly and its upper margin was not made out. Abdominopelvic ultrasound examination suggested right renal agenesis with uterus didelphys. Vagina was seen with cystic mass of 4x9cm extending above to the right side of uterus.

Diagnosis of hematocolpos and hematometra was made, as she gave history of regular menses with imperforate hymen, uterus didelphys with obstructing hemivagina was highly suspected. Her laboratory results were within normal limits. Surgical intervention was decided to release the obstruction. Informed written consent was obtained from patient and parents. Preoperative antibiotic prophylaxis was given. Examination under anesthesia revealed longitudinal septate vagina with obstructed right hemivagina (Figure 2,3). Excision of vaginal septum was done using monopolar diathermy and collected blood was drained. Postoperative recovery was uneventful. Follow up ultrasound after one week showed uterus didelphys with complete clearence of hematocolpos and hematometra.
initial diagnostic method. Resection of vaginal septum and draining of collected blood is the preferred management. Septum resection can be done with preservation of the hymen. Fertility sparing surgery should always be preferred in management of Mullerian anomalies.

**Conclusion**
Uterus didelphys with obstructed hemivagina should always be suspected in cases of imperforate hymen presenting with regular menstrual cycles. These cases may be associated with unilateral renal agenesis. Early diagnosis and management is essential to preserve future fertility. Surgical management is the preferred first line therapy.

**Conflict of Interest:** None

**Source of Support:** Nil

**References**
11. Stussart JP, Nagel TC, Prem KA, Phipps WR. Uterus didelphys, obstructed hemivagina, and ipsilateral renal agenesis: the University of Minnesota experience. Fertil

**Figure 2: Obstructed right hemivagina**

**Figure 3: Left hemivagina seen under anesethesia**

**Discussion**
Uterus didelphys was first termed in 1925 by Wilson in a case with hematocolpos. At 6 weeks of embryonic life Mullerian duct fusion occurs in midline resulting in formation of uterus, cervix and upper 2/3 of vagina. If midline fusion fails, two separate uterine cavities and cervix formation occurs. Metanephrogenic mesoderm and metanephric tubercle fail to develop if Wolffian duct on one side is absent as they help Mullerian duct to fuse. So development of kidney and collecting duct on the same side not occurs.

Mullerian duct anomalies present after puberty. Uterus didelphys with obstructed hemivagina should always be a differential diagnosis in a case with imperforate hymen and regular menstrual cycles. Early diagnosis and management to relieve obstruction prevent future morbidity. Imaging techniques like ultrasonography, hysterosalpingography and magnetic resonance imaging helps in diagnosis of uterus didelphys. Pelvic ultrasound is always preferred as the