# DOUBLE GENITAL PROLAPSE IN UTERUS DIDELPHYS

## (A Case Report)

by

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A case of 2nd degree genital prolapse with a hanging vaginal septum in a case of uterus didelphys is presented.

### CASE REPORT

A 35 years old woman was admitted to U.I.S.E. Maternity Hospital Kanpur on 11-5-81 for something coming out of vagina, since last 6 years.

**Obstetrical History:** $P_3$ + O Last delivery —6 years back. All three were full term normal home deliveries. In the last delivery she had history of retained placenta, removed in some primary health centre by trained nurse.

**Menstrual History:** Menarche was at the age of 11 years. History of dysmenorrhae and menorrhagia was present throughout.

**Physical Examination:**—She was mildly anemic, cardio-vascular and respiratory systems were normal. Per abdominal examination did not reveal any significant finding.

**Per-speculum Examination:**—A loose vaginal septum measuring about 6 cm. was hanging outside the interoitus. On pushing the septum to one side, speculum was introduced on right side of septum. It showed that cervix on right side of septum was desending down upto a level 3 cm. above the interoitus. Similarly, on left side of septum, left cervix was also descending down but descent was slightly less than that of right side. Moderate cystocele was present, but it was looking like a loose bag due to attached vaginal septum. Mild recocele was also present.

**Vaginal Examination:**—Uterus was felt separately on both sides, Retroverted, normal size, firm, mobile. Both adenexae NAD.

**Operative Treatment:**—Patient was kept in lithotomy position. Proper examination was again performed under G.A. and uterine sound was passed on both sides to measure the length of uterine cavity. It was three and half inches on both sides. Loose vaginal septum was held by allis forceps and inverted T. shaped incision was made over it. Vaginal septa was dissected on either side and then bladder was separated by blunt dissection and reflected upwards. Amputation of cervix could not be done separately due to deficiency of tissue on either side for making cervical lips and due to disturbed anatomy. Mackenrod ligaments were dessected on either side (one was present on lateral side of left cervix and one was present on lateral side of right cervix), cut and brought in front of unamputated cervix and tightened there. Bladder supporting sutures were put and redundant part of vaginal wall was cut and remaining was sutured together. Posterior colpoperineorrhaphy was done. Postoperative period was uneventful. She was discharged on 15th postoperative day with the advice to do perineal excercise and to come for followup regularly.

### *Conclusion*

This case is published because of the rarity of double genital prolapse in a case of uterus didelphys and difficulties which can be uncountered during surgical correction of such cases.

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