MANAGEMENT OF LABOUR WITH VAGINAL SEPTUM

(A Report of 9 Cases)

By

NIRMALA KUMARI AND ANUJA ROHTAGI

Introduction

Congenital malformations of uterus and vagina occur more commonly than reported in the literature. They present various problems in labour if not diagnosed prior to it. Majority of abnormalities arise in vagina and are generally the chance finding during vaginal examination. Cases of vaginal septum are encountered commonly. The septa may be sagittal, transverse, crescentic, annular or partial.

We came across 9 cases in a 2 year period in our duty in labour room. Amazingly 4 cases presented in one day with different problems and this prompted us to report this condition.

A sagittal septum with a crescentic lower edge may be present in the upper vagina or throughout its length. It can occur alone or in conjunction with a septate or bicornute uterus and there may be one or two cervices opening into the vagina. This condition arises, either because of late fusion of the mullerian ducts which give rise to two mullerian tubercles or because of failure of proper

Sl. No.	Type of septum	Site of septum	Problems encountered	Mode of deliveries
Sagittal:				
1.	Parital sagittal	½" above the introitus	Obstruction at the outlet	
2.	"	At the level of introitus	"	Forceps application after dividing the septum
3.	"	"	"	
4.	Subseptate	Middle of vagina	Nil	Normal delivery after septum being pushed to one side by foetal heead
5.	"	"	Nil	
6.	Septate without didelphys	Whole of vagina	Nil	Forceps application
Transverse:				
1.	Crescentic	Close to the cervix	Mid cavity obstruction	Caesarean section
2.	Crescentic	"	"	"
3.	Transverse with Central Opening	½" below the external os	"	"

From: Registrar, Department of Obstetrics and Gynaecology, P.M.C.H., Patna.
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canalisation of two sino-vaginal bulbs. Rarely the septum is disposed from side to side and this is explained by rotation of mullerian ducts on each other.

The details of 9 cases is presented here in tabular form.

Management

Nine cases of vaginal septum were dealt with in labour room in emergency. Their ages varied from 18 to 28 years. All these cases were primigravidae except one septate vagina and uterus didelphys whose first pregnancy had ended in abortion at 16 weeks of gestation. All of our cases were diagnosed during pelvic examination when they came in labour. The woman with transverse vaginal septum with central opening gave the false impression of cervix being one finger dilated. The actual condition was diagnosed only when features of obstruction and foetal distress developed for which caesarean section was performed.

In patients who had caesarean section the septum was excised before they were discharged from the hospital.

Co-incidently all the cases reported by us, presented with vertex and none of them had any problem in third stage of labour. The uterus however was explored in all the cases.

Our purpose of reporting these cases is that such conditions should be kept in mind both in pregnancy and otherwise as they may give rise to various types of problems.