An Unusual Cause of Dyschezia: An Incomplete Transverse Vaginal Septum

Nadir Bir Dissezi Nedeni: İnkomplet Transvers Vajinal Septum

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ABSTRACT

A 42-y-old, Gravida 0 woman, who presented with painful defecation was found to have an incomplete transverse vaginal septum at the mid-level of the vagina. No etiological factors explaining the cause of dyschezia was detected via physical examination and imaging methods. The patient was operated by using posterolateral colpotomy technique. A bilateral longitudinal colpotomy of the vaginal mucosa at 4 and 8 o'clock positions was performed. Then the incisions were sutured perpendicular to the vaginal axis. Dyschezia complaint disappeared immediately and completely after surgery. No vaginal stricture formation was observed in a follow-up visit 2 mo after surgery.

Keywords: Dyschezia; transverse vaginal septum; posterolateral colpotomy; surgery; vaginal stricture; painful defecation

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ÖZET

Ağrılı dışkılama şikayeti ile başvuran 42 yaşında Gravida 0 kadın hastada vajinanın orta seviyesinde bir inkomplet transvers vajinal septum saptandı. Fizik muayene ve görüntüleme yöntemleri ile dissezinin nedenini açıklayan herhangi bir etiyolojik faktör saptanmadı. Hasta posterolateral kolpotomi tekniği kullanılarak ameliyat edildi. Saat 4 ve 8 hizasında vajinal mukozanın bilateral longitudinal kolpotomisi yapıldı. Daha sonra kesiler vajinal eksene dik olarak dikildi. Dissezi şikayeti ameliyat sonrası hemen ve tamamen ortadan kalktı. Ameliyattan 2 ay sonra yapılan kontrolde vajinal darlık oluşumu gözlenmedi.

Anahtar Sözcükler: dissezi; transvers vajinal septum; posterolateral kolpotomi; cerrahi; vajinal darlık; ağrılı defekasyon

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INTRODUCTION

Dyschezia is defined as difficult or painful defecation. Its prevalence varies between 6.7 % and 24.5 % in the adult population (1,2). Dyschezia is often related to gastrointestinal disorders, such as anal fissures and colorectal carcinomas (3). Constipation secondary to neurological and metabolic diseases and some gynecological diseases may be additional causes of dyschezia (3,4). Endometriosis is the most common gynecological disease related to dyschezia (5).

A transverse vaginal septum is a rare congenital anomaly and may be complete or incomplete (6). The most common symptoms are primary amenorrhea and cyclic pelvic pain after menarche in complete transverse septum cases and dyspareunia, difficulty in tampon use, dysmenorrhea, and infertility in incomplete septum cases (6,7). This congenital anomaly may also present with unusual symptoms.

In this report, we describe the case of a patient with an incomplete transverse vaginal septum and chief complaint of dyschezia who was treated with a posterolateral colpotomy.

CASE REPORT

A 42-y-old gravida 0 female presented to the gynecology service of a tertiary care center with the complaint of dyschezia for 20 y. Dyschezia persisted when she had constipation or diarrhea. Menarche commenced when she was aged 12 y, and she had regular menses. She was not sexually active and had no other symptoms related to a vaginal septum. Abdominal computed tomography, abdominal magnetic resonance imaging, flexible sigmoidoscopy, and colonoscopy were performed to investigate the etiology of the dyschezia. No intra-abdominal or bowel pathology was detected.

A vaginal examination revealed an incomplete transverse vaginal septum, which manifested as a fibrotic vaginal ring (< 1cm thick) at the mid-level of the vagina (Figure 1). Palpation of the septum caused an intense pain sensation. The cervix was obscured by the septum and was visible only via pelvic ultrasonography. No additional uterine or adnexal pathology was found in an ultrasonographic examination. As no other pathology was detected that could cause dyschezia, surgery was performed to treat the incomplete transverse vaginal septum. Signed informed consent allowing using her medical records and images in scientific paper was obtained from the woman before surgery. Under general anesthesia, a posterolateral colpotomy was carried out. A bilateral 2 cm-long colpotomy of the vaginal mucosa at 4 and 8 o'clock positions was performed parallel to the vaginal axis and perpendicular to the transverse vaginal septum. The left side incision is shown in Figure 2. The incisions were sutured perpendicular to the vaginal axis. Vaginal enlargement (4-cm wide) was achieved at the septum level. The cervix was visible at the end of the procedure (Figure 3). The operation time was about 20 min. The complaint of dyschezia disappeared immediately and completely after surgery. The patient used a vaginal mold for 12 d postsurgery. In a follow-up visit 2 mo postsurgery, completed epithelization of vaginal mucosa was observed, with no stricture formation.

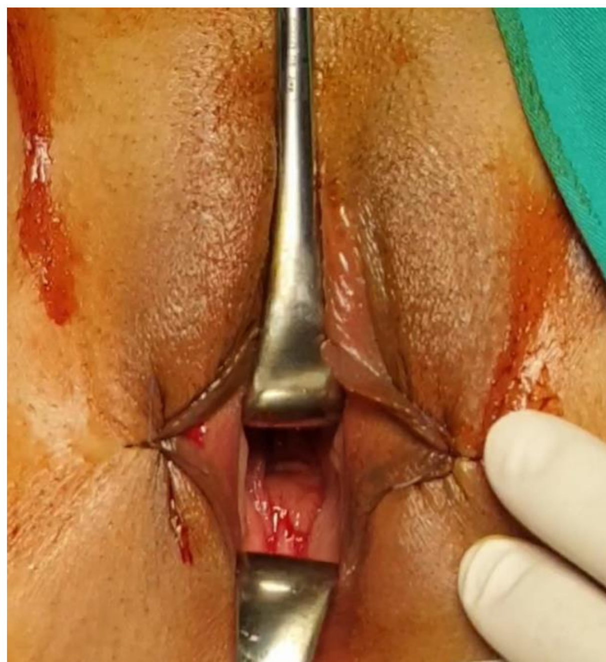

Figure 1. An incomplete transverse vaginal septum at the mid-level of the vagina that obscured the cervix.

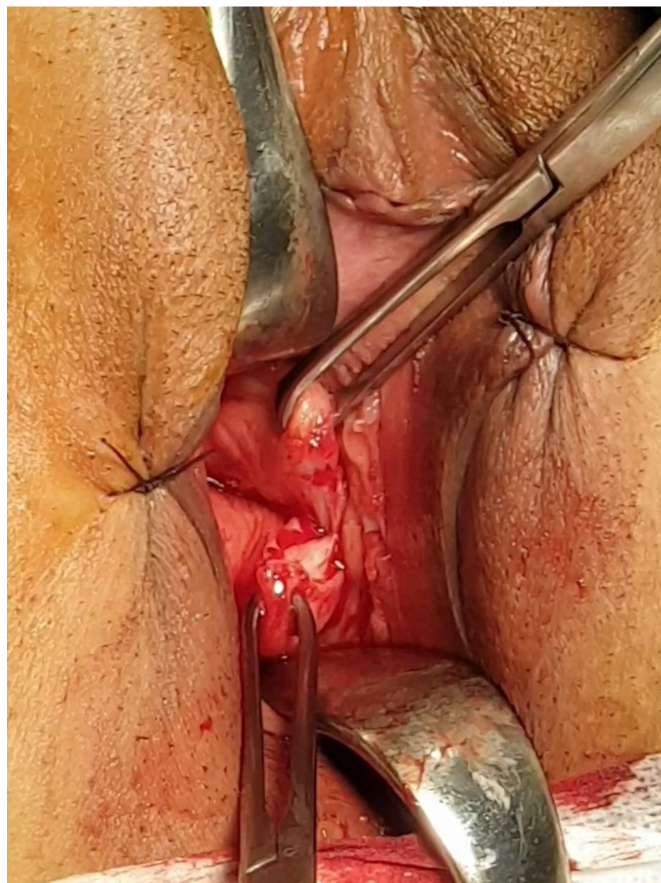

Figure 2. Left side incision: A 2 cm-long incision perpendicular to the transverse vaginal septum at the 4 o'clock position was carried out.

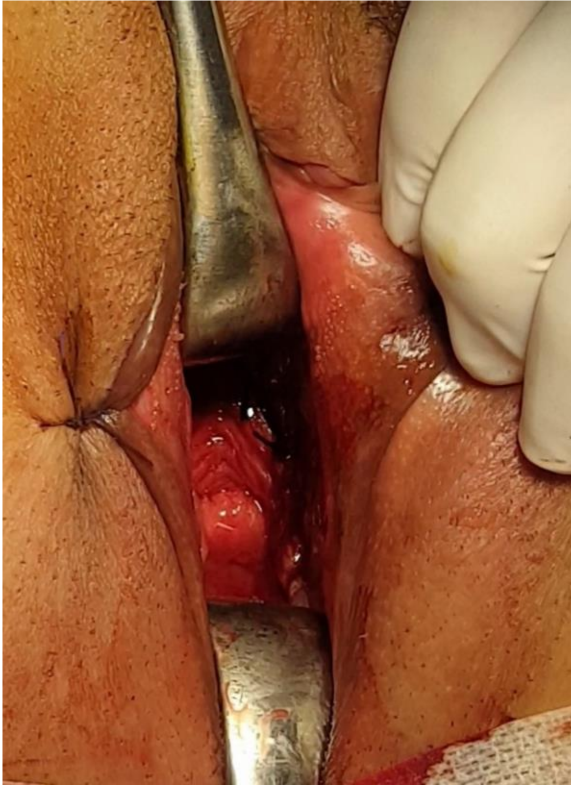

Figure 3. The cervix was visible after the incision was sutured perpendicular to the vaginal axis.

DISCUSSION

The American Society for Reproductive Medicine reported a new Müllerian Anomalies Classification recently (8). Nine anomaly categories including Müllerian agenesis, cervical agenesis, unicornuate uterus, uterus didelphys, bicornuate uterus, septate uterus, longitudinal vaginal septum, transverse vaginal septum, and complex anomalies were defined in this new classification system. Presented congenital anomaly could be included in the transverse vaginal septum category. A transverse vaginal septum is a rare congenital anomaly of the lower genital tract. Dyspareunia and difficulty inserting a tampon are the main symptoms of an incomplete transverse vaginal septum (7). We described a case of an incomplete transverse vaginal septum, where the patient had dyschezia and underwent a posterolateral colpotomy. The patient in the present report presented with chronic painful defecation, which is an unusual symptom of an incomplete transverse vaginal septum. Gastrointestinal disorders and deep infiltrative endometriosis are the main pathologies considered in female patients with dyschezia (3-5). However, as shown in the present case, a transverse vaginal septum was the cause of dyschezia. Clinicians should keep in mind that a vaginal examination may reveal the etiology when no pathology causing dyschezia can be found.

There are a variety of techniques for the surgical treatment of a transverse vaginal septum. These include excision of the vaginal septum and end-to-end anastomosis of the upper and lower portions of the vaginal mucosa, Z-vaginoplasty, abdominoperineal vaginoplasty, and excision with rotation of a perineal skin graft (6,**9**). Postoperative restenosis is an important problem after surgery, and recurrent operations may be required in some cases (6). New surgical techniques are needed to reduce the risk of this complication. In the present case, we used a posterolateral colpotomy technique. Satisfactory vaginal enlargement was achieved, with complete resolution of dyschezia after this procedure. Vaginal restenosis did not occur in the postoperative period. Vaginal restenosis may be less likely to develop with this technique as compared with that of other methods due to the absence of a suture line surrounding the vaginal wall, thereby reducing the possibility of vaginal stricture formation.

CONCLUSION

Presented case showed that a transverse vaginal septum can cause dyschezia. Clinicians should keep in mind that vaginal examination may reveal the etiology of dyschezia in women without common pathologies causing this symptom. In the present case, we used a new surgical technique that can reduce the risk of vaginal stricture postoperatively. Further reports with large case series are needed to evaluate the long-term outcomes of this technique.

Conflict of interest
No conflict of interest was declared by the authors.

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