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Vaginal Delivery of a Breech Presentation in a Full-Term Pregnancy with a Longitudinal Vaginal Septum: A Case Report and Literature Review

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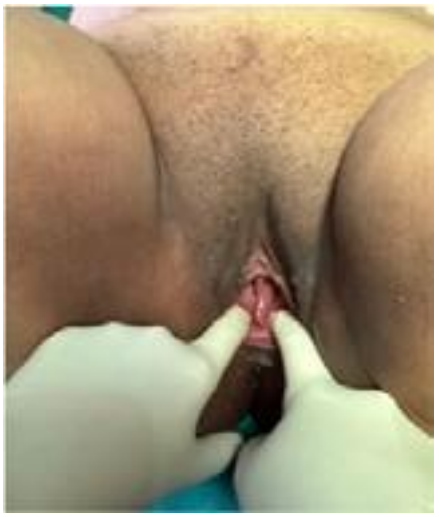
1. Introduction

A vaginal septum is a rare congenital anomaly characterized by the presence of a complete or incomplete partition dividing the vagina into two parallel cavities, resulting from failed resorption of the fused Müllerian ducts during embryogenesis. Patients are often asymptomatic but may present with menorrhagia, dysmenorrhea, dyspareunia, infertility, or spontaneous miscarriage. This anomaly can occur in isolation or in association with other Müllerian anomalies (e.g., septate uterus, uterus didelphys) or renal malformations. We report a case of incidentally discovered longitudinal vaginal septum in a 30-year-old primigravida in labor with a breech presentation at 37 weeks and 4 days, complicated by Intrauterine Growth Restriction (IUGR), at the maternity unit of CHU Ibn Rochd in Casablanca.

2. Case Presentation

A 30-year-old primigravida, with no notable medical history, regular menstrual cycles, and no reported dysmenorrhea or dyspareunia, was admitted to the obstetric emergency department for uterine contractions. The pregnancy was poorly monitored and estimated at 37 weeks and 4 days based on a first-trimester ultrasound. On clinical examination, the patient had normal blood pressure and a negative urine test. Uterine height was 29 cm, uterine contractions were present, and fetal heart sounds were regular and positive. Speculum and digital vaginal examination revealed two vaginal canals separated by a complete longitudinal cervico-vaginal septum measuring 1 cm in thickness. The fetus was in complete breech presentation, with a single cervix found to be fully dilated. The membranes had ruptured four hours earlier, with clear amniotic fluid. Clinical pelvic assessment was normal. Obstetric ultrasound confirmed a single viable fetus in breech presentation, with a posteriorly inserted, non-low-lying placenta. Biometric measurements corresponded to 33 weeks of gestation, and estimated fetal weight was 2250 ± 314 grams. Given the urgency, a local anesthetic procedure was performed to incise and resect the cervico-vaginal septum. This enabled vaginal breech delivery using the Lovset and Bracht maneuvers, resulting in the birth of a female neonate weighing 2400 g with Apgar scores of 10/10. A renal ultrasound was performed postpartum and showed no abnormalities.



Iconography 1: Vaginal septum

Iconography 2: Breech presentation on septum

3. Discussion

The prevalence of uterine malformations in the general population is estimated at 0.5–4% [1-3]. These anomalies, also known as Müllerian anomalies, are classified into seven subtypes according to the American Fertility Society (AFS) and are associated with numerous obstetric complications [4]. Müllerian anomalies have been linked to increased rates of late miscarriages, preterm labor, breech presentations, obstetric complications, perinatal mortality [5,6], vascular disorders of pregnancy, and Intrauterine Growth Restriction (IUGR) [1,7]. These malformations are often asymptomatic and may go undetected until a gynecological exam, infertility investigation, pregnancy, or postpartum evaluation [8]. Associated cervico-vaginal anomalies may include cervical insufficiency or incompetence in up to 30% of uterine malformation cases [9]. Longitudinal or transverse vaginal septa, blind hemivaginas with unilateral menstrual retention, and other anomalies may also be present. Given the common embryological origin of the urinary and genital systems, renal anomalies such as agenesis or ectopia are frequently associated [10,11]. Renal anomalies occur in approximately 20% of cases of Müllerian agenesis (e.g., unicornuate uterus), but are rarely found with other types of uterine anomalies. No specific national guidelines or studies definitively contraindicate vaginal delivery at term in cases of uterine malformations. However, cesarean delivery is often preferred due to altered intrauterine anatomy, which predisposes to recurrent breech presentations [12]. The French College of Gynecologists and Obstetricians (CNGOF) recommends that breech vaginal delivery should only be considered in a "favorable obstetrical context," often excluding known uterine malformations as candidates for vaginal delivery [13]. When diagnosed early in pregnancy, uterine malformations are managed with preventive strategies including rest, fetal growth monitoring, cervical competence assessment, and corticosteroids for lung maturation if needed [14].

4. Conclusion

Genital tract malformations result from developmental anomalies of the Müllerian ducts and account for approximately 10% of infertility cases. The clinical implications vary widely, from simple vaginal septa causing dyspareunia to complete uterine agenesis leading to absolute sterility. Clinicians should investigate the possibility of uterovaginal malformations in cases of primary amenorrhea, abdominal pain, recurrent miscarriages, and adverse obstetric outcomes. Importantly, when such anomalies are diagnosed, urinary tract imaging is essential due to the frequent presence of associated renal abnormalities.

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