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Vaginal Delivery Of A Breech Presentation In A Septate Vagina At Term: A Case Report with Literature Review

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1. Introduction

A vaginal septum is a rare congenital malformation characterized by the presence of a complete or incomplete partition dividing the vagina into two parallel cavities. It results from a failure of resorption of the fused Müllerian septum during embryogenesis.

Patients are often asymptomatic but may present with menorrhagia, dysmenorrhea, dyspareunia, infertility, or spontaneous miscarriage. The condition may occur as an isolated malformation or in association with other Müllerian duct anomalies (such as septate uterus or uterus didelphys) or renal malformations.

We report a case of a vaginal septum discovered incidentally in a 30-year-old primigravida, primipara patient in labor, with breech presentation at 37 weeks + 4 days, complicated by intrauterine growth restriction (IUGR), managed at the maternity unit of Ibn Rochd University Hospital in Casablanca.

2. Results

This is a 30-year-old patient, primigravida/primipara, with no significant past medical history, no history of primary dysmenorrhea or dyspareunia, menarche at age 13, and regular cycles.

She was admitted to the obstetric emergency department for uterine contractions in the context of a poorly monitored pregnancy, estimated at 37 weeks + 4 days based on a first-trimester ultrasound. Clinical examination showed normal blood pressure, negative urine dipstick, uterine height of 29 cm, positive uterine contractions, and regular fetal heart sounds.

Speculum examination and vaginal examination revealed two vaginas separated by a complete longitudinal cervico-vaginal septum measuring 1 cm in thickness, with a complete breech presentation and a single cervix fully dilated. Membranes had ruptured 4 hours earlier, amniotic fluid was clear, and the pelvis was clinically adequate.

Obstetric ultrasound showed a viable singleton pregnancy with positive cardiac activity, breech presentation, posterior placenta not low-lying, and fetal biometry corresponding to 33 weeks, with an estimated fetal weight of 2250 ± 314 g.

A ligation and section of the cervico-vaginal septum was performed under local anesthesia due to urgency, allowing a normal vaginal breech delivery using Lovset and Bracht maneuvers. A female newborn was delivered with Apgar score 10/10, weighing 2400 g.

A renal ultrasound performed later showed no abnormalities.

3. Discussion

In the general population, the frequency of uterine malformations is estimated between 0.5% and 4%. These anomalies, also called Müllerian anomalies, are classified into seven subtypes according to the American Fertility Society (AFS) classification and are associated with various obstetric complications.

In the presence of uterine malformations, rates of late miscarriage, threatened preterm labor, breech presentation, obstetric complications, and perinatal mortality are significantly increased, as well as vascular complications of pregnancy and intrauterine growth restriction.

Uterine malformations may be asymptomatic and remain undiagnosed until incidental discovery during routine gynecological examination, infertility workup, or during pregnancy.

4. Associated Cervico-Vaginal Anomalies

These uterine anomalies may be associated with cervical malformations responsible for cervical incompetence, reported in up to 30% of cases. Longitudinal or transverse vaginal septa may also be present. Blind hemivagina with unilateral menstrual retention can also occur.

The embryological link between the urinary and genital systems explains the frequent association with renal anomalies such as renal agenesis or ectopia. These renal anomalies are found in approximately 20% of Müllerian aplasia cases but are rare in other malformations.

No national recommendations or studies categorically contraindicate vaginal delivery in patients with uterine malformations at term. However, cesarean section is often preferred due to altered uterine anatomy, which favors recurrent breech presentations.

The National College of Obstetricians and Gynecologists recommends that vaginal delivery in breech presentation should only be considered in a "favorable obstetric context," and many uterine malformations are considered indications for cesarean delivery before labor.

When diagnosed early in pregnancy, management is mainly preventive, including rest, fetal lung maturation, ultrasound monitoring of fetal growth, and cervical competence.

5. Conclusion

Malformations of the genital tract are due to developmental anomalies of the Müllerian ducts and represent approximately 10% of causes of subfertility.

Their severity and consequences vary widely, ranging from a simple vaginal septum revealed by dyspareunia to complete uterine absence causing permanent infertility.

Clinicians should investigate uterovaginal malformations in cases of primary amenorrhea, abdominal pain, recurrent miscarriages, or adverse obstetric outcomes.

It is important to note that once a uterine malformation is diagnosed, imaging of the urinary tract should be performed due to the frequent association with renal anomalies.