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## A Case Of Cryptomenorrhea Presenting as - Acute Abdominal pain

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## **CLINICAL HISTORY:**

A 14-year-old female was brought to the emergency department with complaints of acute pain in the abdomen and rectal tenesmus along with altered bowel habits. The patient was on over-the-counter analgesics (antispasmodic - mefenamic acid) for the pain. She was prescribed Cephalosporin and Metronidazole by a general practitioner for suspected amoebiasis. The patient was later referred to the gynecology department following persistent symptoms. The patient complained of having a dragging sensation and feeling of heaviness in the lower abdomen for the past 2-3 months, which has been exaggerated at present. The patient gave the history of experiencing cyclical pain for the past 6-8 months, and on a further query, it was elicited that the patient had not had menarche. The patient had no reported obvious malformation at the time of birth. There was no history of any developmental delay. The patient had no familial history of delayed menses in the immediate family

## **EXAMINATION AND INVESTIGATIONS:**

On examination, the general condition of the patient was well-built with good nourishment.

Physical examination showed well developed secondary sexual characters

Per abdomen, examination revealed a tender mass corresponding to 14 -16 weeks gravid uterus arising from the pelvis.

Local Examination of the vulva revealed an obstruction with no obvious bulge on the Valsalva maneuver

On digital rectal examination (DRE) a tense, compressible pelvic mass was perceived

Routine blood and urine investigations were normal.

Transabdominal ultrasonography showed a fluid-filled uterus with a collection of 11cc. A collection of 220 ccs was noted in the vagina. Differential diagnosis - Hematocolpos with Hematometra. MRI scan revealed an obstruction of 3 cm thickness, with hematocolpos measuring 8 ×9.5 cm. Hematometra was noted. Further MRI showed differential layers of fluid indicative of the retained menstrual products corresponding to the distended uterus.



**Figure 1** -Ultrasound scan showing fluid-filled uterus approximately 11cc with a collection of 220 cc in the vagina



**Figure 2** - MRI scans indicating differential layers of fluid suggestive of blood products

**FINAL DIAGNOSIS:** Transverse vaginal septum

**DISCUSSION:**

The patient underwent surgery for correction of the transvaginal septum and drainage of hematocolpos and hematometra under general anesthesia. The surgical outcome was good.

The transverse vaginal septum is a Mullerian abnormality that results from the incomplete fusion of the Müllerian duct and urogenital sinus component of the vagina. The cause of this genetic abnormality is unknown. It can occur at a different level of the vagina i.e., superior vaginal, mid-vaginal, and inferior vaginal levels. <sup>(1,2)</sup>

It is classified as obstructive/non-obstructive and complete/incomplete. Importance should be given to the fact that the presentation of both imperforate hymen and the transverse vaginal septum is the same at the prepubertal age i.e., cryptomenorrhea.

They both present with one or more of the following symptoms like cyclic pelvic pain, amenorrhea, altered bowel habits, lower back pain, mass in the abdomen, and rarely urinary retention & intestinal obstruction. <sup>(3)</sup>

Imperforate hymen manifest with a vaginal bulge at the introitus (bluish color) while transverse vaginal septum manifests as fibrous tissue blocking the vagina. <sup>(4)</sup>

The difference arises in the thickness of the septum (>3 cm)

The patient in this case report was of menarcheal age with complaints of cyclical pain and deferred menses, based on clinical examination and investigation she was diagnosed as a case of the obstructive transverse vaginal septum at the lower third of the vagina. This malformation was - classified as U0.C0.V3 according to the European Society of Human Reproduction and Embryology classification of congenital malformations (ESHRE).<sup>(5)</sup>

In cases of the obstructive transverse vaginal septum, the timing of surgical repair is controversial, some doctors believe it is best to intervene immediately after the neonatal period, while others believe that surgical repair should be delayed until puberty when estrogenization is complete.



**Figure 3 and Figure 4 - Hymenal opening created**



**Figure 5** - 220 ml of dark tarry blood collected from the vagina after giving central excision on hymen

#### **CONCLUSION:**

We reviewed a case of a 14-year female, an adolescent who presented with acute pain abdomen and additional history of cyclical abdominal pain of 6 months. This report illustrates the importance of the history of cryptomenorrhea and Mullerian abnormalities, important differential diagnosis in patients with such presentation and emphasizes on the need for additional investigations such as MRI for early diagnosis and prompt treatment by surgical repair at diagnosis to improve outcome and prevent complications like restenosis and scarring causing dyspareunia later on. <sup>(6)</sup>

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