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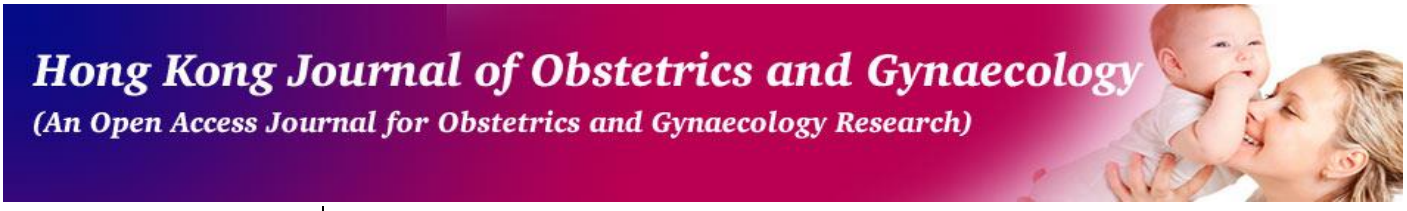


***Case Report***

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# A rare Mullerian Duct Anamoly in premenarchal girl

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## Abstract

**Background:** The unusual presentation of Mullerian duct abnormality. Many cases are still unsolved, particularly if they are asymptomatic. As a result, it is challenging to estimate the real incidence. Most of the gynaecological and obstetric issues are linked to mullerian duct abnormality. **Case Presentation:** We describe a 14-year-old premenstrual girl who had a rare Mullerian Duct Anamoly. She then underwent surgery for uterine abnormality correction via a laparoscopic aided vaginal method. She is currently experiencing oligomenorrhea despite having a normal menstrual period. **Conclusion:** Due to a lack of clinical suspicion and the absence of pathognomonic radiological and clinical features, the majority of mullerian duct anomalies go undetected. An adequate birth strategy can be facilitated and the overall obstetric result can be improved by early diagnosis of mullerian duct abnormalities.

**Keywords:** Mullerian duct anomalies (MDA), Infertility, Premenarchal girl.

### INTRODUCTION

Mullerian duct anomalies (MDA) are uncommon. According to the study, MDA can be of curable infertility. Infertility, repeated first trimester spontaneous miscarriages, foetal intrauterine growth retardation, foetal malposition, premature labour, and retained placenta are more common in patients with MDA [1]. The fallopian tube, uterus, cervix, and the upper two-thirds of the vagina are the structures that make up the female reproductive tract. These tissues grow from a pair of Mullerian ducts. Different embryological beginnings can be traced to the bottom third of the vagina and the ovaries, which come from germ cells that migrated from the primitive yolk sac and the sinovaginal bulb, respectively. Organogenesis, fusion, and septal resorption must all be finished for the Mullerian ducts to develop normally. Both Mullerian ducts originate during the process of organogenesis. If this fails, uterine agenesis, hypoplasia, or a unicornuate ensue [2].

The patient who was admitted with rare anomaly in our hospital presented with complaint of cyclic pain abdomen. On MRI found to be MDA and laparoscopic assisted vaginal reconstruction and neocervix created for the right horn of the uterus.

### CASE REPORT

A 14 year old female patient got admitted with the history of periodic pain abdomen since 6 months. On examination her general condition was fair, conscious and oriented with second degree characters present. Her vital were BP-110/80mmHg, PR-82/min, SPO2-98%. The other systems were normal. The examination of abdomen revealed tenderness in right iliac fossa and local vaginal examination showed hymen intact.Her investigation were, Hb-14.7gm%, platelet count-3,33,000/cumm, total count-9,200cells/cumm. The biochemistry report showed TSH was 1.69µIU/ml, Serum Creatinine was 0.2mg/dl and RBS was 110.6mg/dl. The BT-02.00min/secs and CT was 04.01min/secs. The other parameter like HIV, HbsAg, VDRL were non-reactive and urine routine was normal.

Subsequently she was operated through laparoscopic assisted vaginal route repair of uterine anomaly under spinal anaesthesia and general anaethesia. Veress needle was introduced and pneumoperitoneum was created. 10mm supraumbilical and 2 left lateral ports (5mm) introduced. Vaginal thick transverse septum (a)was resected and mucous collected in vagina was drained. Right cervical hematoma (b) was drained

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under laparoscopic guidance and neocervix was created as shown in figure 1. Foleys catheter was kept inside endometrial cavity. Right hematosalpinx was drained (c). Haemostasis achieved and pneumoperitoneum released and ports were closed. The patient was discharged with following treatment Tab. Augmentin 325mg for seven days and Tab. Rabikind DSR for five days. Post operation on day 2, she was started with oral contraceptives and multivitamins. On her recent visit, on the follow up, she is having her regular menstrual cycle but it's oligomenorrhea.

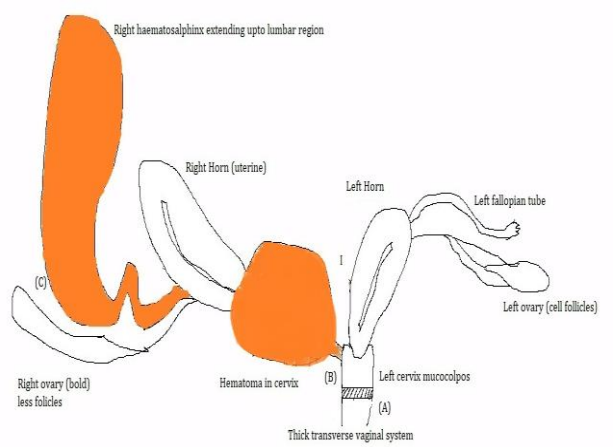


**Fig 1:** The orange color denotes haematoma

**DISCUSSION**

Although uncommon, Mullerian duct abnormalities (MDA) can manifest as mucocolpos, hematocolpos, hematometra, primary amenorrhea, pelvic discomfort, infertility, or recurrent miscarriages from infancy through young adulthood. A definitive diagnosis and the elaboration of secondary findings frequently require additional imaging by MRI, despite the fact that many of these anomalies may be initially recognised at hysterosalpingography or sonography. When assessing MDA, MRI has been reported to be up to 100% accurate [3].

**CONCLUSION**

Due to a lack of clinical suspicion and the absence of pathognomonic radiological and clinical features, the majority of MDAs go undetected. To avoid the wide spectrum of gynaecological and obstetrical difficulties, it is crucial to be aware of its existence and the function of antenatal radiological tests. The optimum delivery strategy will be made possible by early MDA detection, ensuring the greatest outcomes for both the mother and the newborn.

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