A CASE OF DOUBLE VAGINA, WITH OPERATION.

By Hunter Robb, M. D.,
Associate in Gynæcology.

[From *The Johns Hopkins Hospital Bulletin*, No. 39, April, 1894.]

[From *The Johns Hopkins Hospital Bulletin*, No. 39, April, 1894.]

A CASE OF DOUBLE VAGINA, WITH OPERATION.

By Hunter Robb, M. D.,
Associate in Gynæcology.

The history of the case which I wish to report to-night is briefly as follows: L. H., aged 20. Family history good. Has been married for 3 years. Nulliparous. Her catamenia first appeared at the age of 14; they were regular and usually lasted 3 days, the flow being free and unaccompanied by pain. The last menstrual period occurred three weeks before she applied to us at the dispensary. There had never been much leucorrhœal discharge. Her bowels had always been regular. She had not suffered from any urinary disturbance. Beyond this her personal history was negative. The patient came to us complaining from dyspareunia and of severe backache with bearing-down pains, and at times of a burning sensation during urination. Her general condition was good, but it was noted that the thumbs on both hands were found to be curiously undeveloped, being rather short, so that she is scarcely able to make the tips of the thumb and of the little finger meet.

The preliminary examination was extremely unsatisfactory, the patient being so nervous that she would scarcely permit the introduction of the finger into the vagina.

At a further examination under anæsthesia the following notes were made at first: "The mucous membrane about the vaginal orifice is much congested, the urethral orifice is dilated so that the first finger can be easily introduced into the bladder. The vaginal orifice itself is narrow, making the examination difficult. The cervix points downwards and the external os is patulous. The uterus is turned forwards, is freely movable, and is slightly enlarged, its surface being somewhat roughened. The right ovary is small and freely movable. The left ovary cannot be satisfactorily palpated either by examination made through the rectum or the vagina, but with the finger in the bladder the ovary can be easily made out and is found to be small and freely movable."

I had almost overlooked what proved to be the most interesting feature of the case, but my attention having been called to some further abnormality by a member of the class, upon re-examination I found that the examining finger could also be inserted into another opening in the vagina near the left lateral wall. This proved to be a second canal, which extended nearly the whole length of the vagina. A distinct membranous band of tissue separated it from the first. The measurements of the parts were noted as follows: From the upper border of the perinæum to the clitoris 6.5 cm., the remains of the hymeneal folds being found 1.5 cm. within the vagina. The hymen had been centrally perforated; on bringing the portions of the ruptured membrane together the vaginal orifice can be obliterated. The urethral orifice, which is easily dilated to a circumference of 25 mm., forms a depression above the upper limits of the hymeneal fold. The mucous membrane about the urethral orifice is intensely congested. Near the left side of the vaginal orifice there is an area of superficial ulceration measuring 1.5 cm. in diameter. The left lateral cavity is 6 cm. in length, the right 6.5 cm. The cervix uteri occupies the right vagina, being entirely shut off from the left vaginal cavity, which ends in a blind pouch. The pelvic measurement between the two anterior spines is 25 cm. The direct conjugate is 10 cm., and the intertrochanteric measurement is 30 cm. There is also a marked diminution of the hip prominence. The pubic hair runs up into a point towards the umbilicus, after the male type. The vulva externally looks normal. Furrows in vestibule on either side measure 12 mm. in breadth. The escutcheon is well developed, and the breasts look normal.

The operation was performed on March 25, 1894. Upon introducing the blade of a Sims speculum into either orifice, the membrane which divided the two cavities could be easily demonstrated along its whole length. One finger of the left hand was passed along either side of the septum, which was then separated with scissors from without inwards as far as the cervix uteri. The uterine sound was next introduced through the cervix to determine whether or not a septum existed also in the uterus or the cervix, but none was found. The length of the uterine cavity was 7 cm. The vagina was

then thoroughly irrigated with normal salt solution and 10 per cent. iodoformized gauze introduced. The patient made an uninterrupted recovery, leaving the hospital in five days, and has since returned to the dispensary saying that she feels well in every respect, the dyspareunia of which she complained being entirely removed.

In this case it is worthy of note that the urethral canal was used for sexual intercourse.

These congenital anomalies of the genitalia are always interesting, and this one deviates somewhat from the form of double vagina usually met with. It will be remembered that, embryologically considered, the uterus and vagina result from the approximation and coalescence of the second and third portions respectively of the Müllerian ducts. Should for any reason the septum fail to disappear, *i. e.* if coalescence be incomplete, a double uterus or a double vagina or both result, and the double vagina most frequently met with is undoubtedly to be accounted for in this way. But another possibility has to be considered. The third portion of the Wolffian duct (ducts of the mesonephros) runs down on the lateral wall of the vagina and sometimes persists. This duct, commonly known in this region as Gartner's duct, is occasionally patulous; it sometimes opens into the vagina, and may be dilated into cysts of smaller or larger size (vaginal cysts in women and cows). The lateral disposition of the smaller of the two vaginal canals in our case, and the fact that it terminated in a blind sac and was not connected at all with the uterus, might be adduced as evidence of its origin from the Wolffian duct, but on account of its size we are rather inclined to accept the view that the case represents a somewhat unusual double vagina from noncoalescence of the lower third portions of the Müllerian ducts.