

**CONSENSUS STATEMENT: THE MANAGEMENT OF CONGENITAL  
GENITAL TRACT ANOMALIES IN WOMEN.**

The Australian Society of Paediatric and Adolescent Gynaecology (TASPAG) Working Party.

Atkinson E, Bennett MJ (Chairman), Dudley J, Grover S, Matthews K, Moore P, Quinlivan J, Walters T.

Communicating Author:  
Professor Michael J Bennett  
School of Women's and Children's Health  
The University of New South Wales  
C/o Royal Hospital For Women  
Barker Street  
Randwick NSW 2031  
Phone: 02 93826777  
Fax: 02 93826444  
Email: [mj.Bennett@unsw.edu.au](mailto:mj.Bennett@unsw.edu.au)

## **CHAIRMAN'S FORWARD**

A National Consensus meeting was held on Sunday 28th of October 2001 to discuss evidence-based management of vaginal agenesis. Participants were all active members of The Australian Society of Paediatric and Adolescent Gynaecology. Prior to the meeting, an extensive literature review was undertaken to review best clinical practice. The outcomes listed in this document were achieved by complete consensus of participants.

## **CONSENSUS STATEMENT**

The most important aspect of the management of these conditions is

1. Making the correct diagnosis of the underlying abnormality and its anatomy,
2. Documenting any associated renal or skeletal anomalies,
3. Proper preparation of the young woman for any processes to create a new vagina or if indicated, any anticipated corrective surgery.

### **Conditions considered:**

- Imperforate hymen – although this is relatively common - other conditions may mimic this – the most difficult of these is the partial vaginal atresia. Caution needs to be taken before presuming that the problem is simply an imperforate hymen
- Partial vaginal atresia – this can mimic an imperforate hymen, and the management principles are usually closer to those of vaginal atresia than to imperforate hymen
- Vaginal atresia - transverse septa, partial vaginal atresia through to complete vaginal agenesis

### **Vaginal Agenesis and partial vaginal atresia with endometrial function**

- Consider menstrual suppression.
- Consider consultation and referral.
- Suggest ultrasound to be performed by a person with expertise in *gynaecological* ultrasound as these disorders are relatively uncommon and can take different forms.
- Consultation with expert before any surgical intervention. RANZCOG holds contact details of appropriately trained and experienced gynaecologists who are prepared to be contacted for advice regarding these young women.
- Timing of surgery needs to take into account the emotional and physical maturity of the young woman – this may mean delaying surgery for several years. Appropriate menstrual suppression will allow this.
- Attempts at drainage should be avoided, as contamination, infection and scarring can be the consequences, making definitive surgery more complex.
- Best outcome is with the primary operation.

### **Vaginal Agenesis without endometrial function**

- There is no rush, there is time to consult.
- These young women do NOT need a laparoscopy.
- RANZCOG holds contact details of appropriately trained and experienced gynaecologists who are prepared to be contacted for advice regarding these young women.
- Non-surgical approaches should always be considered before surgical approaches.

- There is no indication for doing surgery in childhood. These women need to be psychosexually mature before any intervention is performed
- The use of vaginal dilators results in the successful creation of a vagina in over 80% of young women<sup>1</sup>.
- The initiation of making a vagina with dilators is timed to suit the needs of the young women.
- Referral to specialist centres to gain support for use of vaginal dilators encourages compliance and improves outcomes.
- A successful outcome is not merely the creation of an anatomical vagina, but begins with the psycho-sexual wellbeing
- Support groups may be helpful

### **Investigation of individuals with vaginal agenesis and partial vaginal atresia**

Only a minimum number of investigations are required. These are

- Pelvic Ultrasound (good quality – preferably by a person with expertise in *gynaecological* ultrasound)
- Renal ultrasound – IVP if renal anomaly suggested
- X-ray spine for vertebral anomalies

If renal or vertebral anomalies are identified, echocardiogram may be indicated for cardiac anomalies.

### **Obstructing longitudinal vaginal septum**

- Suggest ultrasound to be performed by a person with expertise in *gynaecological* ultrasound, as these disorders are relatively uncommon.
- Consider consultation.
- Division of obstructing vaginal septum can be undertaken vaginally, laparoscopy is not usually required.
- Information regarding renal agenesis may be helpful as obstruction, if present, will be on the same side as the absent kidney.

### **Uterine anomalies**

- Bicornuate and uterine didelphys may be incidental findings.
- These abnormalities do not require surgery for correction unless there is evidence of a clinical problem
- Removal of a rudimentary horn with endometrium is important due to back bleeding and endometriosis
- Removal of a rudimentary horn without endometrium should be considered due to risk of rupture with ectopic pregnancy

### **Cervical agenesis/atresia**

- Hysterectomy is not mandatory
- Attempts at canalisation may be difficult

## **FURTHER INFORMATION OR ASSISTANCE**

Information and support in the care of young women with a disability can be sought from the RANZCOG or the authors. Contact information for authors willing to provide advice or assistance on these matters is held at RANZCOG ([ranzcog@ranzcog.edu.au](mailto:ranzcog@ranzcog.edu.au)).

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Note: This statement was endorsed by RANZCOG Council, February 2003