A young girl presented with complaints of dysmenorrhea and cyclic pelvic pain for one year. She had normal menarche and regular menstrual cycle. On physical examination there was tenderness in right lower quadrant.
Figure 1. USG shows two widely separated uterine corpII, a non obstructed normal appearing left uterus [Fig. 1a], and hematometra, hematosalpinx in right uterus [Fig. 1b], normal right ovary and hematometra in right uterus [Fig. 1c].

Figure 2. Axial T2W AND T1W images show widely divergent uterine horns, non-obstructing normal left uterus, and hematometra and hematosalpinx in obstructed right uterus.
Figure 3. Sagittal T2WI images reveal two separate uterine corpi with right blind ended uterus. Figure 3b shows non-obstructed uterus opening into vagina.

Figure 4. Coronal T2WI images of abdomen show ipsilateral renal agenesis on right side.
Figure 5. Schematic diagram shows uterine didelphys with unilateral vaginal agenesis and ipsilateral renal agenesis.

Diagnosis: Uterine didelphys with unilateral vaginal agenesis and ipsilateral renal agenesis (OHVIRA)
Findings: Ultrasound findings show two widely separated uterine corpi, a non-obstructed normal appearing left uterus and cervix, and hematometra, hematosalpinx in right uterus.
MRI findings include widely divergent uterine horns, non-obstructing normal left uterus and cervix opening into vagina which communicates with external opening, and hematometra and hematosalpinx in obstructed right uterus which ends as a blind end cavity and does not show any communication with vagina suggestive of vaginal agenesis.
Additional imaging of urinary system shows renal agenesis on right side.
Discussion: Mullerian duct anomalies are congenital anomalies which results from non-development, defective vertical or lateral fusion, or resorption failure of mullerian (paramesonephric ) ducts. MDA have been classified by American Society of Reproductive Medicine according to patients clinical presentation, treatment and prognosis(1).
I Müllerian agenesis or hypoplasia
II Unicornuate uterus
III Uterus didelphys
IV Bicornuate uterus
V Septate uterus
VI Arcuate uterus
VII DES-related uterine anomalies

Classification of Vaginal Anomalies
I Transverse vaginal septum (obstructing or non-obstructing)
II Longitudinal vaginal septum (obstructing or non-obstructing)
III Stenosis or iatrogenic cause

OHVIRA syndrome is typically associated with type III MDA (uterine didelphys) with two uteri, two
cervices and two vaginas, one of which is obstructed, and associated with renal agenesis on the side
of hemivaginal obstruction, but this case is a variant of described OHVIRA as it was renal agenesis
with ipsilateral complete vaginal agenesis instead of vaginal obstruction by transverse (type I) or
longitudinal (II) vaginal septum.

OHVIRA results from embryonic arrest at eight weeks of gestation which affects adjacent mullerian
and metanephric ducts. The defect may also occur as early as the fourth week of gestation and can
affect both the mesonephric ducts and ureteral buds. The mesonephric duct, which is maldeveloped,
does not allow crossover of the mullerian duct and consequent fusion results in a didelphys uterus
and obstruction of the ipsilateral horn and the vagina (2).

Clinically, patients with OHVIRA usually present due to symptoms from obstruction. Almost uniformly
this presentation occurs at or after menarche when the hemiuterus or hemivagina becomes
symptomatic and the patient experiences cyclical dysmenorrhea. This results in retrograde
menstrual flow and may present as a unilateral abdominopelvic mass on physical examination.
Complications associated with this disorder are endometriosis, pyosalpinx, pyocolpos and pelvic
adhesions.

Imaging is usually done when patient presents with complaints of abdominopelvic pain and cyclic
dysmenorrheal. Since the other non obstructive uterus is normally functional, infertility is a rare
presentation. Ultrasound findings include two widely separated uterine corpili, a non-obstructed
normal appearing uterus and cervix opening into vagina, hematometra and hematosalpinx in other
uterus, however exact cause of obstruction is difficult to evaluate on sonography and further
imaging is required.

MRI is the imaging investigation of choice in such cases due to multiplanar capabilities, high soft
tissue contrast and no risk of radiation. MRI findings include non-obstructing normal uterus and
cervix opening into vagina which communicates with external opening. Hematometra and
hematosalpinx in obstructed uterus which ends as a blind end cavity, and does not show any
communication with vagina suggestive of vaginal agenesis.

Imaging of urinary system is imperative to perform in presence of mullerian duct anomalies or vice
versa. Differential diagnosis is uterine didelphys with hemivaginal obstruction by transverse or
longitudinal vaginal septum or imperforate hymen.

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Disclosures:

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