A Photo Album of Pediatric and Adolescent Gynecology

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KEYWORDS

• Images • Cases • Dysmenorrhea • Amenorrhea
• Vulvar diseases • Pelvic neoplasms • Pelvic mass
• Mullerian ducts • Pelvic pain

During the past decade as the sole pediatric and adolescent gynecology subspecialist in a tertiary care academic center, the author has had the privilege of caring for many patients with many problems, some common and some unique or challenging. Often these patients and their families have allowed the author to take photographs (protecting their anonymity) with the understanding that educating health care providers is an essential part of ensuring that other young girls who have similar conditions will receive the care that they need. This article presents a selection of images depicting pediatric and adolescent gynecologic conditions that, although not particularly common, present with a relatively common complaint such as dysmenorrhea, pelvic mass or pain, genital irritation, and amenorrhea. Health care providers who recognize the unusual underlying condition will save patients and their families days, weeks, or even years of misdiagnoses, frustration, fear, or even pain and suffering. When possible, references to useful publications/articles about the particular conditions are provided. Textbooks on pediatric and adolescent gynecology also devote full chapters to each of these four topics.[1–3]

DYSMENORRHEA

Most cases of dysmenorrhea in adolescents represent primary dysmenorrhea; that is, prostaglandin-mediated physiologic menstrual cramping associated with ovulatory cycles. Because perimenarchal girls are not always ovulatory, early menstrual cycles often are irregular and painless. Girls who do experience primary dysmenorrhea should get relief from properly administered non-steroidal anti-inflammatory drugs (NSAIDS), and for those who still suffer, the combined use of oral contraceptives and NSAIDS usually suffices. When these strategies fail, or when severe pain accompanies early cycles, other underlying conditions, such as obstructive Müllerian congenital anomalies (see the article by Breech in this issue), endometriosis (see

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the article by Templeman in this issue), constipation, and pelvic adhesions, should be considered.[4–18]

Case 1: Obstructed Non-Communicating Uterine Horn (Figs. 1A, 2)

A 12-year-old complained of predominantly right-sided dysmenorrhea beginning with menarche. She visited the emergency department with each of her first three menstrual cycles. A routine ultrasound did not identify any abnormality, but the MRI was classic for a non-communicating right-sided obstructed uterine horn adjacent to a normal left hemi-uterus with patent outflow tract. After excision of the non-communicating horn, the patient experienced only mild central dysmenorrhea that responded well to NSAIDS. Although this horn was removed by laparotomy, laparoscopic excision is possible, depending on the junction and the surgeon's comfort and skill. Removal of the horn did leave a bed of myometrium on the left uterus that required layered closure. Although the recommendation is controversial, the patient was advised to discuss elective cesarean with any future obstetrics care provider (see Case 4 and references listed regarding myomectomy and future obstetric uterine rupture). (For a list of useful references, see the discussion of dysmenorrhea in the previous paragraph.)

Case 2: Obstructed Hemi-Vagina with Right Hematocolpos (Figs. 1B, 3–6)

A precoital 17-year-old girl did not experience dysmenorrhea until 3 years after she began menstruating. She was thought to have primary dysmenorrhea, but instead of improving with treatment with NSAIDS and an oral contraceptive pill, the problem seemed to be worsening. The patient began to notice intermenstrual

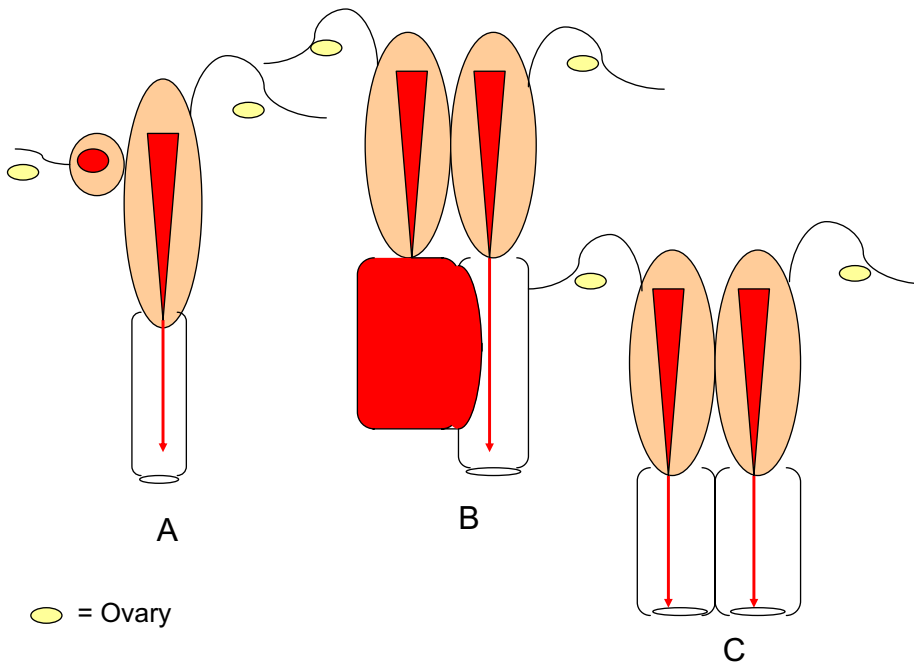

Fig. 1. (*A*) Noncommunicating R uterine horn (Case 1). (*B*) Obstructed R Hemivagina (Case 2)–often associated with Ipsilateral Renal Agenesis (OHVIRA). (*C*) Uterine Didelphys with complete longitudinal vaginal septum (Case 3).