A-053

# Management of reformation of imperforate hymen following hymenectomy by double cross plasty technique

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**ABSTRACT**

**Introduction:** Imperforate hymen occurs in 1 in 2,000 females. Standard surgical treatment of imperforate hymen involves either hymenotomy or hymenectomy. In most cases, this simple surgery is sufficient to manage the condition. Reformation of imperforate hymen and stenosis of the hymenal opening are rare complications following surgery. Double cross plasty is a surgical technique normally performed to manage transverse vaginal septum. It results in less risk of future vaginal stenosis compared to the old technique of excision and repair. This technique can also be used in managing imperforate hymen. **Case Description:** A 21-year-old lady presented with dyspareunia and difficult coitus; where full penile penetration was not possible. She underwent hymenectomy for imperforate hymen at the age of 12 years old. Several years post operation, she started to notice 'bulging of the hymen/vagina' each time during menses. Perineal examination showed reformation of imperforate hymen with a stenotic pin point opening. Double cross plasty was the surgical technique used to manage the condition successfully. **Discussion:** Reformation of imperforate hymen is a rare complication following surgery. Double cross plasty is a good surgical technique for both primary hymenal surgery or for reformation of imperforate hymen as illustrated in this case.

**Keywords:** imperforate hymen; reformation; double cross plasty

A-054

# Gestational gigantomastia – A rare and debilitating disease

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**ABSTRACT**

**Introduction:** Gestational gigantomastia (GGM) is characterised by a rapid and disproportionate enlargement of the breasts during pregnancy. It is a rare condition with an incidence of 1 in 28,000 to 1 in 100,000 pregnancies worldwide. **Case Description:** We present a case of a 29-year-old lady, G2P1 who presented with 2-months history of painful bilateral breast swelling from 15 weeks of gestation. She stopped breastfeeding her first child once this pregnancy was confirmed. Clinical examination revealed erythematous bilateral breast enlargement. She was initially treated with multiple courses of antibiotics for bilateral cellulitis with mastitis. Several biopsies were taken in which showed lactational adenoma or acute on chronic mastitis. The pain and erythematous area improved with antibiotics, however both breasts continued to enlarge excessively throughout the pregnancy. The revised diagnosis of gestational gigantomastia was made and she was started on steroid. Nevertheless, she failed to respond. Oral Bromocriptine 2.5 mg OD was commenced at 29 weeks and there was reduction in size. During the treatment course, the fetus was found to have asymmetrical IUGR at 34 weeks. She subsequently delivered at 37 weeks via caesarean section. **Discussion:** A thorough workup including serum markers for infection, electrolytes, hormonal profile, and tissue biopsy should be done to rule out other causes in women presenting with gigantomastia in pregnancy. Treatment is controversial. These ranges from conservative hormonal therapy, reduction mammoplasty, and mastectomy with or without reconstruction.

**Keywords:** gestational gigantomastia, mastitis, breast reduction mammoplasty