To the Editor: We have read with interest the article entitled “New classification of Herlyn–Werner–Wunderlich syndrome (HWWS)” by Zhu et al.\(^1\) and we want to clarify a few points.

Such syndrome, although often reported as such in the literature, does not exist. Herlyn–Werner syndrome in their original description is a unilateral renal aplasia, with double uterus and blind vagina presenting as Gartner’s pseudocyst. In the Wunderlich syndrome, the blind hemivagina is developed and filled with a large hematocolpos. The symptoms and management of these entities are different.

It is true that the exact etiology of such anomalies is still unknown, but it has been established that they have their origin in a mesonephric (Wolffian duct) anomaly.\(^2\) The mesonephric anomaly with the absence of the Wolffian duct opening into the urogenital sinus and therefore of the ureteral bud sprouting, justifies the blind vagina and unilateral renal agenesis. The uterine anomaly (didelphys, bicornuate, and rarely, septate uterus) is due to the absence of the “inducting” function of the injured mesonephric duct on the Müllerian duct, being thus a consequence.

We published in 2010, a large institutional series of 60 patients with unilateral renal agenesis focusing on the gynecological associated pathologies,\(^3\) which the authors do not seem to have found in their search, maybe due to the incorrect use of MeSH terms.

Most important, we published in 2004\(^4\) and updated in 2011,\(^5\) a female genital tract malformations classification which included the claim “New classification of HWWS” and that the authors seem neither to have found. We there proposed a subdivision for the mesonephric anomalies presenting with: (a) Large hematocolpos in a blind hemivagina (Wunderlich syndrome); (b) Gartner’s pseudocyst in the anterolateral wall of the permeable vagina (frequently as a Herlyn–Werner syndrome); (c) partial reabsorption of the inter vaginal septum; and (d) complete unilateral vaginal or cervico-vaginal agenesis with or without communication between both hemiuteri.

Finally, we recommend the authors to review their Figure 4\(^6\) which is incorrectly drawn. If there is a communication between hemiuteri, this will be located at the inferior uterine segment of both hemiuteri. This also has an embryological explanation: It is the closest portion between both Müller ducts and the point where the fusion and reabsorption processes between both start before simultaneously proceed cranially and caudally.

Authors’ Reply

To dear Dr. Maribel Acién and Pedro Acién: Thank you for your comments on our paper entitled “New classification of HWWS.”\(^6,7\) We appreciate your contribution about female genital malformations very much. We perused your article published in 1992, 2004, 2010, and 2011 and are impressed by your study in the embryological and clinical aspects of female genital malformations.

We agree that the absence of the “inducting” function of the injured mesonephric duct on the Müllerian duct had been established as the origin of such anomalies. We did not include it, as it is not the main concern in our paper.

We have explored the clinical characteristics of HWWS and have published related papers in recent years.\(^6,7\) Based on these papers, we proposed the classification. Various genital abnormalities divided according to the complete and incomplete obstruction were easier to understand and could be treated effectively.

The main purpose for the classification of this syndrome was to obtain an early diagnosis, treatment, and improve fertility. As the diagnosis and treatment center for female genital malformations in the Mainland of China, our department had our own database on the basis of hundreds of female genital malformation patients. As the key-point for treatment of “HWWS” is the resection of the vaginal septum, we propose the term of “oblige vaginal septum syndrome (OVSS)” instead of “HWWS” as the former is easier to understand. “OVSS” has been widely accepted in the Mainland of China these years. By the use of “OVSS” and the classification, we hope to decrease misdiagnosis and improper treatment for patients with this syndrome.

Sorry for the incorrect part in Figure 4. Thank you for your comments on our paper (Dr. Lan Zhu, Department of Obstetrics and Gynecology, Peking Union Medical College Hospital, Peking Union Medical College and Chinese Academy of Medical Sciences, Beijing 100730, China. E-mail: zhu_julie@vip.sina.com).

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There are no conflicts of interest.

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