

HAEMATOCOLLIS

(A Case Report)

by

ANUSSYA DASS,* F.R.C.O.G., BHAGAVANTI G. KOTWANI,** M.R.C.O.G.

and

SAROJ BALA ARORA,*** M.D.

Obstructive lesions of the genital tract leading to accumulation of the menstrual blood may be congenital or acquired. Haematocolpos is not infrequently seen in the gynaecological outpatient department whereas haematometra and haematocollis are very rare. In the entire literature we have come across only two cases of haematocollis cited by Jeffcoate. On account of the extreme rarity of the condition the following case is being presented.

Case History:

Patient aged 29 years was admitted on 26-4-69 with a history of pain in the lower abdomen and amenorrhoea for the last four months. She gave history of some local vaginal treatment administered by a midwife 5 months ago as the patient had a history of sterility of 7 years' duration. There were no urinary or rectal symptoms.

Menstrual history—Menarche at the age of 12 years, periods were regular 4/28 till 4 months ago.

Examination—well nourished young woman, pulse 80/minute, B.P. 120/80 mm. of Hg. Systemic examination revealed no abnormality.

Abdominal examination — There was a mass arising from the pelvis, size of 14

*Prof. of Obst. & Gynec.

**Asso. Prof. of Obst. & Gynec.

***Lecturer in Obst. & Gynec.

Maulana Azad Medical College and Associated Irwin & G. B. Pant Hospitals, New Delhi-1.

Received for publication on 15-4-1970.

weeks of pregnancy, with restricted mobility.

Per vaginam — The vagina was of normal depth and there was a big, soft, cystic swelling, size of 3½ x 3½ inches at the vaginal vault in the place of the normal cervix, but no external os could be palpated. Uterus was normal in size and firm in consistency, felt sitting at the top of the soft mass.

Per speculum — Vaginal walls normal. No abnormality detected. A rounded, smooth mass with a small bluish area in the centre visualized at the vaginal vault.

Provisional diagnosis—Haematocollis.

Investigations

Hb. 9.5 gm.%, WBC 9200/cu., poly., 61%, lympho 35%, eosinophil 3%, monocytes 1%, Urine

{ Sugar
Alb. } N.A.D.
Micros. }

Blood urea, 25mg.%

Plain X-ray abdomen and I.V.P.—N.A.D.

Vaginal and urethral smear—N.A.D.

Operation:

Vaginal examination under anaesthesia was carried out and the above findings were confirmed. An aspiration needle was inserted through the discoloured area and thick old dark blood was aspirated. The same opening was enlarged with the sinus forceps. A kidney tray full of old blood was drained. Sound passed, went in for a length of 6½". Though attempt was made, the internal os could not be located properly. Both lips of the cervix were caught with a sponge-holding forceps and the anterior lip of the cervix was outlined by

making a circular incision at the junction of the vagina with the cervix. The bladder was reflected upwards and then anterior and posterior flaps inverted by anterior and posterior Sturmdorff sutures constituting the new external os. Two lateral haemostatic sutures were applied at 3 and 9 O'clock positions. The sound could now be easily passed into the uterine cavity for $4\frac{1}{2}$ ".

Post-operative period was uneventful.

Repeat vaginal examination was carried out on 14-5-69. Cervix was well outlined, downwards, and backwards. Uterus anteverted normal in size, fornices were clear. Uterine sound was introduced. Total length of the uterus was 3" with cervical length $3\frac{1}{4}$ ".

Histopathological report of the cervix—Ch. cervicitis.

Hysterosalpingogram done on 14th Sept. 1969 showed normal uterus and tubes with normal internal os.

Comments

Atresia of the cervix may be due to a congenital or an acquired lesion, the latter being more common than the former. Obstruction may be at any level i.e. at the external os, in the canal or at the internal os. Cervical atresia usually leads to haematometra though the possibility of haematocollis occurring is also there. Study of 100 cases of obstructed cervixes by Melody in 1957 revealed that 30 cases were congenital whilst 70 were due to acquired lesions. Congenital obstruction of the cervix was due to failure of non-canalisation of the fused Mullerian ducts. In acquired atresia it was either due to trauma, amputation, infection like gonococcal, tubercular, cauterisation, neoplasm or post irradiation. Masani (1967) collected 13 cases of cervical atre-

sia and in every case he found haematometra. Atresia was due to congenital lesions in six and acquired factors in 7. None of his cases had a haematocollis. Solomon's two cases of haematocervix are described by Jeffcoate. In both there was non-canalisation of the vagina with haematocervix with a normal uterus. In these cases an artificial vagina was constructed and communication was established between the cervix and vagina by an abdominal operation.

In our case haematocollis due to congenital factors was excluded because patient was having normal regular periods four months before admission. There was no other history on repeated questioning. Probable cause of cervical atresia in our case could be some chemical irritant introduced by an untrained midwife for the treatment of infertility. The irritant could have resulted in denudation of cervical epithelium around the external os which later healed by fibrosis and was epithealised. It is probable that the trauma was superficial as seen by the enormous dilatation of the cervix and the integrity of the cervical canal. It is difficult to explain why a haematocollis and not a haematometra was the result of the obstruction.

References

1. Jeffcoate, T. N. A.: *Principals of Gynaecology*, 1967, p. 184.
2. Masani, K. M.: *J. Obst. & Gynec. India*, 17: 543, 1967.
3. Melody, G. F.: *Surg. Gynec. & Obst.*, 85: 50, 1949.
4. Melody, G. F.: *Obst. & Gynec.* 10: 190, 1957.

See Fig. on Art Paper III