A CASE OF HYPOSPADIAS IN A FEMALE

by

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Hypospadias in the female is a rare condition. Only 46 cases have been reported, predominantly in adult women. It has has been observed thrice in young girls.

Campbell (1970) states that the meatus may open abnormally at any point from the usual orifice position, to the bladder neck. In the last instance the condition is like a vesico-urethro-vaginal fistula with incontinence.

Associated genital abnormalities were an enlarged clitoris and displacement towards the anus of all the openings of the urovaginal structures. In several women there was a small vagina and a common outlet. Intraurethral intercourse had been practised.

CASE REPORT

A nineteen year old girl was admitted on 3-7-1970 with a history of primary amenorrhoea and stress incontinence as well as frequency of micturition since one year.

Patient was married since one and a half years. She had sex relations after marriage for three months, except for dyspareunia and a little 'spotting' for a few days. She gradually noticed that she had frequency of micturition, stress incontinence and even bed wetting at night. She emphatically stated that she had no bed wetting nor such frequency of micturition before marriage. Present frequency of micturition was ten times during day and twice during night.

On examination the patient was a well nourished young girl with a congenital harelip on the left side. Her measurements were as follows:

Height 61½", Span 60½" upper segment 25", lower Segment 36½". Secondary sex characteristics were normal. Breasts were well developed, distribution of pubic and axillary hair was normal. External genitalia were normal.

On vaginal examination, there was a blind pouch of 1 to 1½ inches in length with an opening in the anterior vaginal wall which was in direct communication with the bladder, the mucosa of the bladder could be seen. There was no urethra. Two fingers could be passed easily through the opening into the bladder. Urine came out of the opening during examination. No cervix or uterus was felt, the fornices were clear. All other systems were normal.

The following investigations were done: RBC—4,000,000 per cm., haemoglogin 11.5 gms., Blood urea-31 mgm.%, Blood sugar 89 mg.%.

Urine examination did not show anything abnormal.

Vaginal cytology showed moderate oestrogen deficiency.

Buccal smear-4 to 6% of cells chromatin positive.

Intravenous pyelogram did not show any congenital anomaly of the urinary tract.

Screening of the chest—lung fields clear. Heart in its normal position.

Gynaecography—showed no uterus or ovaries.

Cystoscopy was not possible, bladder mucosa around the opening was seen and after injecting indigocarmine ureteric orifices could be seen.

Exploratory laparotomy was done on 29-7-70 under spinal anaesthesia. A normal right tube and ovary attached to a small solid mass, the rudimentary right half of the uterus was seen. Left ovary was absent. Lower end of the left Mullerian duct

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was thickened to form a solid rudimentary left half of the uterus with a small underdeveloped left tube. Round ligaments were normal. There was a well developed fold of peritoneum between the bladder and the rectum. The patient was in hospital for nearly two months. During this time she regained control over the bladder and had no bed wetting. The urologist advised urinary diversion but the patient was not willing to undergo the operation as she had no bed wetting when she refrained from intercourse.

Discussion

This patient had no incontinence of urine until she got married. The vagina being very shallow and small, intercourse must have been intravesical giving rise to stretching of the opening in the bladder leading to incontinence. The bladder musculature around the opening served as a sphincter and there was no incontinence before marriage.

As regards the treatment, construction of the urethra with large long flaps of lateral urethral wall and vaginal mucosa brought together over a catheter with suprapubic drainage, has been advised. Lapides states that construction of a long urethral tube of normal calibre will itself promote urinary continence. In this case there was no urethral wall and even the vagina was very small and shallow so that adequate flaps would not have been obtained.

The other alternative was to transplant the ureters into the rectum or construct an ileal loop bladder. This had been suggested to the patient but she preferred to remain continent by abstaining from intercourse and returned to her parents home.

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References

1. Campbell Meredith and Hartwell Harrison Urology, Vol. 2., Philadelphia, London Toronto, 1970, W. B. Saunders Co.
2. Lapides quoted by Campbell.