HAEMATOMETRA WITH CONGENITAL ATRESIA OF VAGINA AND CERVIX

by

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Introduction

Haematometra due to congenital atresia of the vagina and cervix is not a common condition and only a few cases have been reported in the literature. Two case reports of haematometra due to congenital atresia of the vagina and cervix are reported.

Case 1

J. M., aged fifteen years, married for three years was admitted at Malda District Hospital on 16-6-72 for, (a) attacks of severe lower abdominal pain at monthly interval for nine months, (b) gradual swelling of the lower abdomen for six months, (c) difficulty in sexual relation.

General examination revealed nothing abnormal.

Abdominal Examination: A midline globular cystic tender to touch was felt in the lower abdomen arising from the pelvis. The size was that of twenty weeks' pregnant uterus.

Pelvic Examination: External genitalia were normal, but the vaginal orifice was represented by a dimple. The tissue behind the dimple was fibrous in nature yielding about half an inch to pressure (Fig. 1).

Rectal Examination: The tender mass was high up in the pelvic cavity corresponding with the lower abdominal mass.

Laboratory investigations did not reveal any abnormal finding.

A provisional diagnosis of haematometra due to congenital atresia of vagina was made.

Management: Operation was performed under general anaesthesia on 23-6-72.

The fibrous tissue behind the dimple at the vaginal orifice was incised transversely and an artificial space between the bladder and the rectum was dissected upto the lower end of the tense swelling. There was no cervix. The space was packed with roller gauze.

The abdomen was opened by a suprapubic midline incision. The uterus was enlarged to the size of twenty weeks' pregnant uterus, cystic and tense to the feel, the lower segment being more distended than the upper segment. Both the fallopian tubes were distended. There was spilling of chocolate coloured blood in the peritoneal cavity. There were no intra-abdominal adhesions (Fig. 2).

The diagnosis of haematometra with haematosalpinx was confirmed.

The peritoneum over the stretched lower segment was incised transversly and the bladder was pushed down. The haematometra was drained by incising the lower segment.

As there was no cervix. an opening was made in the lower end of the uterus and a wide polyethylene tube was passed through the opening into the artificial space between the bladder and the rectum made previously. The incision in the lower segment was closed. The abdomen was closed in layers.

The polythelene tube was stitched to the artificial opening of the uterus with nylon through the artificial space (Fig. 3).

Post operative Care: Intramuscular injections of tetracycline were given for seven days.

The polyethylene tube was removed after one month from the date of the operation.

The artificial space between the bladder and the rectum was kept patent by intermittent stretching.

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She had a period on fifth week after operation.

After six week from the date of the operation, skin grafting of the artificial space between the bladder and the rectum was done. The whole thickness of skin was taken from the thigh. Skin grafting was done by wooden mould covered by polyethelene sheath. The graft took well within twenty one days.

Follow-up: The patient started having regular monthly periods. The artificial vagina was dilated regularly by a mould supplied to the patient. The vagina measured 3.25 inches in length (Fig. 4). Sexual intercourse was initiated three months after the original operation. There was no trouble.

Insufflation test was done on 19-9-72. It was found to be negative on either side.

Fifteen injections of Placentex (Placental extract) were given intramuscularly, on alternate days.

Insufflation test was repeated on 23-10-72. The left tube was found to be patent.

Case 2

L. M., aged 16 years, unmarried was admitted on 15-3-70 in the surgical ward as an emergency for, (1) acute pain in the lower abdomen for two days associated with vomiting, and (2) periodical attacks of severe pain in the lower abdomen for two years.

General Examination: The patient was short in stature, imbecile with presence of cleft palate and hair lip.

The patient was dehydrated due to vomiting. Pulse was 116 per minute. The systolic blood pressure was 110 mm Hg.

Abdominal Examination: The abdomen was distended and tender to touch. There was a tender lump in the lower abdomen deviated to the right side. The bowel sounds were accentuated.

A provisional diagnosis of intestinal obstruction from appendicular lump was made and the surgeon decided to perform laparotomy. Intravenous 5% Glucose Saline drip along with gastric Suction was started.

Laparotomy was done on 16-3-70. The pelvic cavity was found to be full of old blood clots. The uterus was enlarged to the size of sixteen weeks' gestation and cystic to feel. Both 'the fallopian tubes were dilated and full of blood clots. The ovaries were normal.

The uterus, tubes and ovaris were densly adherent to each other, the surrounding intestines and pelvic tissues, forming a single mass. The author was called in for help.

As the patient had no menstruation before, a case of haematometra with haematosalpinx was suspected.

There was no vaginal cavity and the vaginal Orifice was replaced by a dimple. The diagnosis of haematometra due to congenital atresia of the vagina was confirmed.

Conservative surgery to preserve the uterus and ovaries was contemplated but during dissection, the adhesions were so dense that there was no other alternative but to perform hysterectomy. The left ovary was preserved. There was atresia of cervix also.

Intravenous drip and gastric suction were maintained for 72 hours. Antibiotics were given.

The question of artificial vagina did not arise as the parents decided not to get their daughter married.

Comments

Haematometra due to congenital atresia of the vagina and cervix is not a common condition.

If the uterus is absent or functionless the above condition is no problem. When the uterus is functioning, menstrual blood collects behind the congenital obstruction at monthly interval. The commonest cause of cryptomenorrhoea is an imperforate hymen or a vaginal septum just behind the hymen. In this condition haematocolpos is the primary feature, haematometra being a late manifestation.

Vaginal cavity has unlimited capacity to stretch and pain is never severe in haematocolpos and the patient seeks medical advise late. In a case of haematometra due to congenital atresia of the vagina, the severity of pain is so marked

that the patient seeks medical advise earlier.

Misdiagnosis with pregnancy, acute or subacute appendicitis, ovarian cyst and tuberculous peritonitis is not uncommon. The second case was misdiagnosed as intestinal obstruction from recurrent attacks of appendicitis.

As the patients are adolescent and the uterus with fallopian tubes readily recover after evacuation of haematometra and haematosalpinx conservative surgery is the treatment of choice.

In long standing neglected cases, radical surgery, hysterectomy with salpingectomy is required.

The main principle of conservative surgery is to keep the artificial uterine opening and artificial vagina patent to maintain free flow of menstrual blood and normal sex relationship. Postoperative infection should be checked.

Masani in his paper has discussed the problem of haematometra in details. According to him, the largest number of reported cases of haematometra are of congenital malformations, 46 per cent in his series of reported cases.

Summary

(1) Two cases of haematometra due to congenital atresia of the vagina and cervix are reported.

(2) In one case conservative surgery with restoration of normal menstruation and a functionating vagina was successfully performed.

(3) In the second case radical surgery was necessary.

Acknowledgement

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References

1. Masani, K. M.: J. Obst. & Gynec. India. 17: 543, 1967.

See Figs. on Art Paper VI