VAGINOPLASTY—A MODIFIED TECHNIQUE

by

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The aim of this article is to report 2 cases in whom there was functional uterus associated with congenital noncanalization of upper vagina in one and of lower vagina in the other. The operative technique had to be modified in such a way that the surgery not only enabled satisfactory coitus but also facilitated menstrual flow and possibility of conception.

According to Jones (1959) it was Wharton who used a mould in the first instance for vaginal construction. McIndoe (1950) made the ingenious addition of split thickness skin graft over the mould. In 1950 he reported excellent results in 50 out of his 65 cases. Bryan *et al* in 1949 reported 70 such operations with good results in 75% of the cases. Since then, there have been numerous reports of this operation being performed successfully. However, in almost all these cases vaginoplasty was done primarily to maintain vaginal patency for coital purpose.

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The clinical material is from Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry 605 006.

Accepted for publication on 29-3-1978.

Case Reports

Case 1

16 year old girl with primary amenorrhoea complaining of cyclical spasmodic abdominal pain during 3 days every month since 1½ years. The pain increased gradually.

On examination she was found to have complete absence of vagina. On rectal examination there was an oblong smooth cystic nontender mass 10 cm x 7 cm approximately 5 cm above vulva anterior to the rectum.

Case 2

17 year old girl with primary amenorrhoea complained of cyclical pain abdomen during 8 days every month since 1 year. The pain increased gradually.

On examination the external genitalia were normal. Vagina admitted 2 fingers but ended blindly about 4 cm above introitus. No evidence of haematocolpos made out. On rectal examination a small cervix and uterus were felt anterior to rectum.

Operative Technique

In both these cases the following surgical procedure was undertaken:

Patient in lithotomy position—A "H" incision made at the dimple which marked the site of vagina between external urethral meatus and the anus. The assistant keeps a finger in the rectum to avoid injury and to guide the operator along the correct plane. A rubber catheter kept in situ—By blunt dissection a canal was made between the urethra and bladder anteriorly and the rectum porteriorly taking special care to secure haemostasis. At the apex of this canal, haematocolpos of upper vagina was encountered in case 1 and the cervix in case 2.

A split skin graft was taken from the thigh and was fixed over a hollow acrilic mould in such a way that the raw area of skin faced outwards. This was inserted carefully inside the newly constructed vagina and the edges of skin graft sutured with fine silk to the introitus. The mould was kept in place by tying tapes through the metal hooks in the mould and fixing them around the things.

Postoperatively patient was given antibiotics and her bowels bound for 7 days. Continuous bladder drainage was needed. Dressings were changed on the 7th day. The skin graft had taken up completely and the vaginal capacity was normal. Vagina was irrigated with saline daily. The patient used the mould almost continuously while in the hospital and was instructed to use the mould every night for 3 months and then to resume regular sexual intercourse. If unmarried the mould may have to be used for 6 months.

Discussion

Case I: The diagnosis was haematometra, haematocolpos of upper vagina and noncanalization of lower vagina. While operating the haematocolpos was incised in cruciform manner and after draining 20-30 ml of menstrual fluid the edges of upper vaginal wall stitched all round the constructed vagina. A small cervix was visualised and the hollow mould allowed drainage of the menstrual fluid postoperatively. The surgery was done on 9-1-1974 and the patient was discharged on 13-3-1974. For nearly 9 months until January 1975 she did not report for follow up. She had married meanwhile and was practising regular satisfactory coitus. Her periods were regular and normal. On examination the vaginal capacity was normal.

Case 2: This patient had undergone unsuccessful vaginoplasty twice before, once in 1970 and once in 1972, before this procedure was undertaken. During the first operation haematometra was drained. On both occasions a wooden solid mould covered with rubber condom was used without skin graft. This produced considerable discomfort and the patient stopped using the mould even while being inside the hospital. Granulation tissue filled up upper vagina but there was drainage of menstrum through a sinus. This sinus was dilated once on 22-3-1972 to facilitate better drainage.

The third procedure was done on 15-1-1975. While dissecting along the dense fibrous tissue surrounding the cervix a portion of the ectocervix was excised inadvertently. After identifying the os dilatation of cervix and curettage was done. Postoperatively the patient used the mould for 4 months and then remarried. She had satisfactory sexual intercourse. She underwent a curettage on 29-8-1977 for spasmodic dysmenorrhoea which is her only complaint at present.

Conclusion

Two young women have been successfully operated by a modified McIndoe technique of vaginoplasty. The result has been satisfactory from the point of view of menstruation and sexual intercourse. It remains to be seen whether they concieve in due course of time.

References

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