CONGENITAL ABSENCE OF VAGINA WITH MENSTRUAL RETENTION AND VAGINOPLASTY

(A Case Report)

by

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Introduction

Various types of vaginal deformities leading to primary amenorrhoea have been described by Dewhurst and Gordon (1969), Dewhurst (1977), Chakravarty *et al* (1977). Many reports have also been published highlighting different methods of management of such cases (MacIndoe and Banister, 1938; Villiams, 1964; Chakravarty, 1977).

This report deals with one case of primary amenorrhoea having lower vaginal atresia with accumulation of menstrual blood in the upper vaginal pouch and its management. The young patient is now happily married following operative construction of her vagina and is also having regular menstruation. If this case had posed such a simple problem as caused by haematocolpos due to an imperforate membrane at hymenal level, it would have required little or no discussion at all. But, the more serious problem of retention of menstrual flow high in the genital tract in which the lower part is absent does require consideration.

CASE REPORT

The patient, Miss B. M., aged 19 years, came to the Gynaecological Outdoor of Calcutta National Medical College, Calcutta, on the 11th of January, 1977, for primary amenorrhoea and monthly lower abdominal pain for 1 year.

General Physical Examination: Her height was 5 ft. 1 inch. She had well developed secondary sexual characters with normal axillary and pubic hair. (Fig. I).

Abdominal Examination: A 2" x 2" suprapubic lump was palpable slightly to the right of the midline. It was firm, mobile from side to side. The lower margin could not be delineated. The lump was slightly tender.

Vulval Inspection: Labia majora and minora were well developed with no signs of virilization. There was no vaginal introitus between a dilated urethra and the anus; instead there was a white membrane with its concavity outside. No bluish protruding membane could be detected (Fig. II).

Rectal Examination: The upper half of the vagina was found to be distended. Neither the uterus nor the lower half of the vagina could be palpated.

Special Investigations: Buccal smear was examined and the patient was found to be chromation positive. Intravenous pyelography (Fig. III) and cystoscopy revealed no abnormalities of the urinary tract.

The patient was admitted in the hospital and laparotomy was performed by pfannenstiel incision. The uterus was found to be of normal size with normal bilateral fallopian tubes (Fig. IV). The uterus was sitting upon a distended vagina. The vaginal vault was pierced posteriorly by a syringe and needle and dark coloured blood mixed with mucus could be aspirated into the syringe Fig. V). The cervix could then be felt through the vagina. The ovaries were healthy looking on both sides. Ovarian biopsies were taken (the histopathological report later showed that the ovaries were normal

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with functioning follicles and evidence of corpus luteum). The abdomen was closed in layers.

An artificial vagina was made. A catheter was put into the bladder. A transverse incision was made on the depression just below the urethra. The dissection was carried out upwards with special care to avoid bladder and bowel injury (Fig. VI). Soon, the blind pouch in the upper vagina could be reached and was incised open, when dark coloured blood came out in gushes (Fig. VII). A cylinderical mould was left in the newly constructed vagina.

After two weeks, a skin graft (taken from her thigh) on a cylindrical mould was placed in the recently constructed lower half of the vagina. It was stitched to labia minora.

Follow-up: The patient was discharged from the hospital after 6 weeks. The lower part of the vagina was nicely epithelised. She was advised to dilate her newly constructed vagina with dilators. In the meantime, she had started menstruating on her own. After 6 months she got married. She is now having regular menstruation with no difficulty in her conjugal life.

Discussion

When the patient was first examined, an abdominal lump could be palpated, but the uterus could not be felt on rectal examination. Laparotomy was performed to visualise the genital organs. She was found to possess a normal sized uterus with bilateral tubes and healthy looking ovaries in contrast to lower vaginal atresia. After aspirating blood from the distended upper half of the vagina the cervix could be felt through the vaginal vault, it was thought that the defect could possibly be only in the lower vagina. So the abdomen was closed and the lower vagina was constructed. The problem of keeping the new vagina open has been overcome by Jeffcoate (1969) by his advancement operation in which the upper vaginal tissues are brought down to the introitus to line the new vagina. Another method is to cover the lower part with a split skin graft as in the operation of MacIndoe—Read vaginoplasty. Another alternative is to fold in flaps of valval tissues into the new lower vagina (Dewhurst and Gordon, 1969). Chakravarty has used amniotic membrane in place of skin graft (1977). In this case, the skin graft was not placed immediately because of the collected blood was trickling out of the vagina. Only a mould was kept inside to prevent adhesion in the newly built canal. After 2 weeks, the discharge dried up and the skin graft wrapped over a mould was placed in the vagina. The taking of the graft was perfect. After that, regular dilatation with vaginal dilators for 6 months and her conjugal life when she got married helped in maintaining the capacity of the newly constructed vagina without any stricture. Regular menstruation was established without any hormonal treatment.

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See Figs. on Art Paper VI-VII