PREGNANCY FOLLOWING SUCCESSFUL REPAIR OF ACQUIRED OBSTETRIC VAGINAL ATRESIA

(A Case Report)

by

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Vaginal atresias are mostly of congenital origin and acquired atresias are very rare. The latter may be due to chemical burns, infections, local obstetric or other trauma.

Vaginal atresia resulting from obstetric trauma is rare, and very little material is described in the Literature.

Here, we are reporting an interesting case of acquired vaginal atresia following a difficult forceps delivery, repaired by vaginoplasty twice. Later the patient conceived and was delivered by elective caesarean section.

CASE REPORT

Mrs. V., Para I, aged 24 years was admitted on 18-7-79 with the complaints of painful coitus and scanty painful periods of 3 years duration following her first delivery. Her menstrual periods were usually regular and painless but following her first delivery, the periods became scanty and painful, though regular. She had I full term forceps delivery in a district headquarters hospital, 3 years prior to admission. She gave history that she had ruptured the membrances at home and she got admitted into the hospital 48 hours later where she had a very difficult forceps delivery and the baby was dead born. She had a very stormy puerperium due to puerperal sepsis and was treated in the same hospital for 32 days and was discharged. When she resumed marital relations she experienced dyspareunia, and when periods were established they were scanty and painful.

On admission, the patient was a normal healthy woman, 148 cm tall and her other systems were normal. Local examinations of the external genitalia showed that the perineum was scarred with an old episiotomy wound on the right side. Vaginal introitus was admitting a finger only for deapth of 1 cm. Vagina was occluded by a dense scar and vaginal examination could not be done. Uterus could be palpated by rectal examination.

When the patient was examined under anesthesia in the operation theatre, the above findings were confirmed. In addition, a tiny hole admitting the probe was made out in the midst of scar tissue. Uterine sound was passed through the tiny hole to a length of 7 cms but dilatation could not be done due to the dense scarring. A diagnosis of acquired vaginal atresia was made and patient was prepared for vaginoplasty.

During the surgery the scar was found to be extending from the introitus to the cervix all round. The cervix was separated from the scar and the dense scar tissue was excised and a

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patulous vagina about 5 cms was dissected. The general surgeon helped us in taking the skin graft, a sponge mould was prepared, A McIndoe's type of vaginoplasy was done and the prepared mould was inserted into the newly formed vagina. The labia were sutured to prevent slipping of the mould. On the 10th day, the mould was removed and further digital dilatations were done for 15 days. She was discharged well with instructions to dilate the vagina with Hegar's dilator daily. It was found on review a month later (20-10-79) that restenosis had occurred as the patient did not dilate properly for fear of pain.

The patient was readmitted for repeat Mc Indoe's operation. Because of the rapid restenosis, she was investigated for Lymphograuloma—Venereum and was found to be negative. Scar tissue was biopsied to rule out lichen sclerosis and the pathology report showed only fibrous scar tissue and no evidence of lichen sclerosis.

A repeat MacIndoe's operation was done on 12-11-79. This time, a polyweld acrylic mould used in dentistry was used instead of sponge. The mould was expelled on the 12th day spontaneously. On examination, the graft had taken up well with the vagina of 5 cm depth. Patient was discharged well and instructed to dilate the vagina with polyweld mould daily for 3 months and also to have natural dilatation. The patient was having periodical check up. Both husband and wife reported satisfactory painless coitus.

In April 1980, patient reported with history of 3 months amenorrhoea and was found to be pregnant, she had regular antenatal check up. She was delivered of a live female baby of 3.2 kgm by lower segment caesarean section on 22-10-80. Mother and baby were discharged well on the 10th day.

Summary

A rare case of acquired vaginal atresia resulting from obstetric trauma who had successful vaginoplasty and conceived is reported here because of its rarity.