WILLIAM'S METHOD OF VAGINAL CONSTRUCTION

(A Case Report)

by

K. LALITHA,* M.D., D.G.O.

and

SANTHAMMA MATHEW,** M.D., D.G.O.

Introduction

Congenital abnormalities of the genital tract are, fortunately, rarely seen. When absence of vagina is associated with absence of uterus and appendages, the part of the surgeon is simplified, because all be has to provide is a functioning vagina. In such circumstances, simple technique like Williams is highly acceptable.

CASE REPORT

A woman aged 21 was seen in our O.P. with history of primary amenorrhoea. She attained menarche, at the age of 16 and got married 3 months back. Patient did not volunteer about difficulty in coitus. But on questioning the husband, he said that there was difficulty.

Examination Findings: The patient was a normal looking female with feminine behaviour. Secondary sexual characters were well formed.

On local examination upper half of the vulva was normal. There was no vaginal introitus but there was a sort of dimple and some lax skin at the site. Vagina was non-canalised. On rectal examination uterus and ovaries were not felt. Laparoscopy was not done because the presence of a menstruating uterus was thought unlikely. Hormonal status was normal and other routine investigations also were normal. A diagnosis of Mullerian agenesis was made.

The husband and wife were told about the examination findings and about the operation outcome. Operation was performed on 3-11-80.

Operation Technique. After routine preparations patient was placed in the lithotomy position. During was done in the usual manner. A Foley's catheter was put into the bladder. (Fig. 1). The line of incision was marked with methylene blue. The line was U shaped, extending across the fourchette and forward along the labia majora to a point little above the urethral meatus roughly 4 cms lateral to the meatus. The line of incision was infiltrated with a solution of saline with epinephrine about 10.15 ml. The incision was placed along the marked line and deepened through full thickness of fat and fascia till bulbospongeosus was visualized (Fig. 2). Care was taken to obtain the greater part of fat and labial tissue to the medial flap so as to obtain good mobility and support to the newly formed vagina.

The skin was joined by interrupted stitches with atraumatic 'O' chromic catgut. The stitches were taken in such a way that knots were lying within the lumen. Then a piston of a 20 ml syringe was kept in the new vaginal lumen and the fatty tissue was sutured over the skin with interrupted catgut stitches. This would help to avoid narrowing of the lumen. (Fig. 3). After releasing the lithotomy position the skin was closed with cotton stitches. Length of the vagina in completion of operation was 8 cm. (Fig. 4) and dressed with sofratulle.

Post operative care: Continuous bladder drainage for 7 days was kept and so also bed rest and urinary antibiotics were continued for

*Associate Professor of Obstetrics & Gynaecology.

**Tutor in Obstetrics & Gynaecology, SAT Hospital, Trivandrum.

Accepted for publication on 18-1-82.

7 days. Abduction of legs was avoided by loose bandage. Daily perineal attention was given. Stitches were removed on the 7th day and the wound was healed perfectly well. There was no postoperative problems and patient was discharged on the 10th day. On reviewing the case after 6 weeks the perineum was looking normal. She had no problem for micturition. The couple was seen few months after the operation normal coitus was possible both of them were satisfied and happy.

Summary

The easy approach is much laudable and so also less post operative care and attention. Since there is not much operative skill involved this can be done in any hospital. Satisfactory resumption of function with least effort is much to be appreciated.

Acknowledgement

We are grateful to the Director and Professor of Obstetrics and Gynaecology and superintendent, S.A.T. Hospital.

See Figs. on Art Paper VII