VAGINOPLASTY AND REPOSITION OF VESTIBULAR ANUS "COMBINED APPROACH"

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SUMMARY

This is a very rare case of congenital total vaginal atresia with normal functional cervix, uterus and its appendages along with a vestibular anus, who presented with cryptomenorrhea and acute abdomen, an emergency condition.

The management in this case is unique because of combined approach at the same sitting by Gynaecologist, plastic surgeon and Pediatric Surgeon, performing temporary colostomy followed by anoplasty, correction of vaginal atresia by reconstructive surgery with McIndo's skin graft, and drainage of haematometra through a rubber catheter put into the cervix to keep the graft dry.

It is always desired to confirm this diagnosis before laparotomy is undertaken for mistaken diagnosis of acute abdomen which occasionally simulates this condition by all possible means. This type of case should ideally be dealt vaginally.

Introduction

We were faced with a problem of congential total vaginal atresia with functioning uterus and vestibular anus a very rare anomaly. In addition, emergency created by the onset of menarche and formation of haematometra left very little time to plan the strategy. Successful outcome of this case with combined approach by three specialists e.g. gynaecologist, plastic surgeon and pediatric surgeon is presented here.

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Clinical Picture

History – young girl aged fourteen attended Gynaecology Department, Safdarjung Hospital, New Delhi in December, 1983 with a history of monthly attacks of severe abdominal pain of 3-4 days duration for last 4 months. The parents were aware of some congenital anomaly in the genital tract and were awaiting

onset of menarche to start treatment.

Examination

General – Average built and nourished, secondary sexual characters well developed.

Respiratory cardiovascular system and per-Abdomen examinations – revealed no abnormality

Local Examination

1. Anal opening-inside the introitus at posterior margin of fourchest. Small skin dimple seen at the site of normal anus.
2. Hymen fully covered by a thick membrane and appeared blind.
3. Urethra and vulva-normal.

Per-rectal Examination

Inspite of abnormal position of anal opening rectal examination was easy.

About 2 1/2" above anal opening, a soft cystic non-tender mass was felt about the size of 10 weeks uterus in the midline. No separate uterus was felt.

Provisional Diagnosis

Vaginal atresia (Total or partial) with Haematometra or haematocolpos and vestibular anus.

Investigations

1. Routine investigation like haemoglobin and urine were within normal limits.
2. Examination under anaesthesia - confirmed the same findings.
3. Laparoscopy showed:-
   a) A normally developed uterus enlarged to about 8-10 weeks pregnancy size with slight deviation to right side.
   b) Both tubes and ovaries appeared normal.
   c) It was not possible to confirm the presence of haematocolpos.
4. Ultrasound

   Confirmed the presence of enlarged uterus with haematometra. Extent of vaginal atresia or haematocolpos could not be definitely seen. Some doubt of cystic swelling on right side – suggestive of haematosalpinx was seen on ultrasound.
5. Intra-venous pyelogram excluded any urinary tract abnormality.

Patient was put on Primolut-N 5 mg twice daily to suppress the menstrual bleeding and monthly attacks of pains. She continued to take the same for 4 months after the operation till the graft was completely taken up.

Procedure

1. As a first step – a temporary colostomy was done. Once it started functioning the lower part of sigmoid and anal canal was subjected to daily washings and cleaning for nearly 2 weeks.
2. Replacement of vestibular anus in its proper place was done by making a circular incision around the anal opening and all round dissection for a length of nearly 2-2 1/2" taking special care anteriorly for urethra and bladder. A cruciate incision was made in the dimple present at the normal site of anal opening and anal canal was brought out from it and fixed there.
3. Attempt was made to create perineal

body by putting a few interrupted catgut stitches in lower border of levators to support the anal canal anteriorly. In the space already created, a cystic mass of collected blood could be felt covered by a thickish tissue and not the thin membranes etc, as is described in the text books. With blunt dissection about 55 cc of thick blood was let out. To our surprise upper 1/3rd of vaginal mucosa was not developed at all. In the dissected space dilated cervix was seen to be flushed with top of the space draining the blood from uterine cavity. No normal vaginal mucosa of vault or upper 3rd of vagina was seen. After all the blood was let out, catheter was put in through the dilated cervical canal and brought out from the MacIndoe's foam rubber mould.

MacIndoe's Vaginoplasty

A total thickness skin graft was taken from the medial aspect of the right thigh, which was stitched all round a mould made of foam rubber. This was placed on the raw space created in between bladder and Rectum to be taken up and function as vagina. The catheter inserted into the dilated cervical canal was brought out through it to make effective drainage of old clotted blood and menstrual flow. The mould was stitched all round the introitus at labial margins.

Post Operative Care

1. Continuous catheterization of bladder for nearly 3 weeks was done. Initial vaginal mould was taken out on 4th day under G.A. when most of the graft was found to have taken up.
2. 2nd plastic mould was kept for 7 days.
3. Under General anaesthesia again examination was done and plastic mould of smaller size was kept till all the oedema and tissue reactions subsided, dilatation of anal canal was also done at the same sitting.
4. Colostomy was closed after about 1 1/2 months of the main operation.
5. 3 months after the operation Primolut-N was stopped and she got her first normal painless period.
6. Plastic mould was kept in for nearly six months regularly. Patient herself was trained to remove and clean the mould whenever necessary.

Post Operative result (Follow up)

1. Patient is getting regular menstrual periods.
2. There is complete control over anal activity.