CONGENITAL CERVICAL ATRESIA WITH ABSENCE OF VAGINA WITH FUNCTIONING UTERUS. ABDOMINOPERINEAL APPROACH FOR RECONSTRUCTION

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SUMMARY

Congenital atresia of the cervix with absence of vagina poses challenging problems to the treating gynaecologist. The following paper discusses the management of four such cases. All the four patients were managed by abdominoperineal reconstruction followed by vaginoplasty by McIndoe technique and one had vaginoplasty by Jeffcoat's technique. All the patient's had restoration of vaginal mestrual flow. However, one of them needed hysterectomy for un controlled sepsis subsequently.

INTRODUCTION

Congenital absence of vagina with cervical atresia with a functioning uterus above, poses most difficult problem regarding management and success. Though an artificial passage is constructed to drain the menstrual discharge the future reproductive outcome is not always satisfactory as in most cases the tubal epithelium is destroyed due to haematosalpinx. Management of 4 such cases is presented.

Case No. 1 : Ms A.S., 24 yrs., unmarried lady was admitted on 02.09.1986 with complaints of periodical attacks of pain in lower abdomen with primary amenorrhoea. Her secondary sex characters were well developed and abdominal examination was normal. Only lower 1/3rd vagina was present, Rectal examination revealed presence of haematometra and haematosalpinx. Routine blood and urine examination was normal. Pyelogram showed double collecting system on left side. Buccal smear showed 46xx, 45xo. Laparotomy (04.09.1986) findings were an arcuate uterus of 6 weeks size with both sides haematosalphinx and chocolate cyst in left ovary. An artificial vagina was created and Cx was felt. Abdominally bladder was reflected down and vertical incision of 2 cm made in the body

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of uterus and sound passed through this opening to the Cx and gradually dilated with metal dilator. Finally a 26 No. Malecot catheter was passed through the Cx in the neovagina from the uterus, and abdomen closed in layers. A vaginal mould of rolled foam sponge covered with condom and then split skin graft was applied over it was made. Through its central core malecot catheter was taken out of the uterus. A continuous bladder catheter was kept for 7 days and mould was removed on 9th day and was replaced by glass mould and patient was instructed to wear it regularly.

Case No. 2 : Ms A., aged 15 yrs., was admitted on 29.10.1986 with C/o cyclical lower abdominal pain and absence of menstruation and an attempted vaginoplasty at other centre. Her secondary sexual-characters were well developed. She had polydactly in left foot. On abdominal examination, a soft mass of 5 cm x 5 cm was palpable in suprapubic region. On vaginal examination lower 1/3rd of vagina was present and a tight ring was felt in the upper part. Chest X-ray showed right ventricular hypertrophy, her buccal smear was positive and intravenous pyelogram was normal. An abdomino-perineal approach as in case one was performed (21.01.1986). Abdominal findings were uterus bulky, bilateral haematosalphynx, Rt normal ovary, chocolate cyst it ovary. Drainage procedure done through vaginal mould with McIndoe technique as in previous case, she was discharged on 27.12.1986. Subsequently patient did not turn up for follow up and she reported in the month of May, 1988 with acute abdomen due to attempted cervical dilatation elsewhere. Local examination showed a stenosed vagina and no external cervical, Os, bilateral T.O. masses could be located. Decision for subtotal hysterectomy with excision of left T.O. mass was taken on 01.07.1988. Post-operative period was uneventful.

Case No. 3 : Ms S., aged 14 yrs.,, was admitted on 05.12.1987 with complaints of cyclical lower abdominal pain and primary amenorrhoea. Her secondary sexual characters were normal. Abdominal examination revealed nothing abnormal. Local examination showed absent vagina and uterus of 9-10 weeks size, Cx was not felt. Her buccal smear was positive and pyelogram was normal. An abdomino-perineal approach operation was performed on 01.01.1988 as in first case. On laparotomy uterus was bicorunate, bulky left sided haematosalpinx and dense adhesions were found in P.O.D. Metroplasty with left sided excision of haematosalphinx with McIndoe vaginoplasty was done. Post-operative care was done as in case one and was discharged on 10.02.1988. She was having regular menstruation.

Case No. 4 : Ms G., aged 13 yrs., was admitted on 27.02.1988 with cyclical lower abdominal pain for one year and primary amenorrhoea. Her secondary sexual characters were normal. On abdominal examination 10 "x8" mass felt on suprapubic region. Local examination showed absent vagina and on rectal examination cystic mass of 25 cm x 10 cm was felt through rectum. On laparotomy uterus was normal and pouch of doglous was free, drainage of haematometra by cervical dilatation and vaginoplasty was performed by Jeffcoat's (1987) method. Post-operative period was uneventful. Patient is having regular menstruation.

DISCUSSION

Atresia of the vagina with an absent uterus poses little problems regarding management, as management of these cases can be deferred till the patient reaches marital age when reconstruction of vagina following the method of McIndoe and Bannister (1938)

and Williams (1974) may result in a vagina of almost normal capacity. Presence of functioning uterus forces surgeon to take up the case early due to onset of retrograde menstruation leading to endometriosis and tubo-ovarian mass as in case No. 3. These patients due to tender age pose difficulty in post-operative management.

We preferred abdomino-perineal approach rather than only perineal approach as the operative technique. This gives better idea of the uterus and adnexae and secondly better identification of cervix. Moreover, corrective surgery as for example metroplasty and excision of T.O. mass in case No. 3 could be done at the same time. Similar approach has been advocated by Roychowdhury and Sikdar (1979) and Chakravarty (1977) with favourable results. Regarding construction by mcIndoe and Banister (1938) technique of vagina, use of sponge-roll covered with condom and split thickness skin graft with a central hole for the passage of Malecot catheter is less discomforting and avoids pressure necrosis. Regarding results of our cases, 3 of the 4 cases are having successful menstruation and the first case got recently married leading to a normal marital life. The second case was a failure because of the mismanagement of the case at another centre and hysterectomy had to be done at a later stage, for uncontrolled sepsis. Nivor et al (1980) had recommended hysterectomy as a primary procedure. But in our set up this should be done only when primary approach at conservation of uterus fails.

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