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Acute Retention of Urine Due to Senile Vaginitis

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Case Report

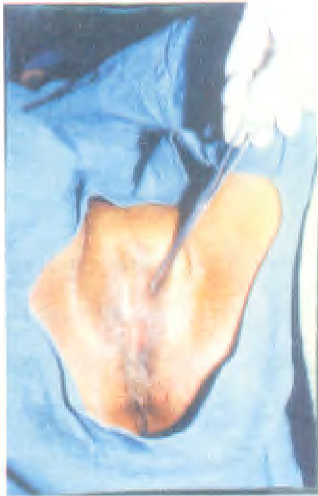
A post menopausal, grand multiparous woman aged 75 years presented to the O P D with complaint of acute retention of urine for the past 12 hours associated with severe pain. She gave a history of difficulty in passing urine and dribbling of urine on straining since 2 months.

Vital signs and systemic examination were normal except that the bladder was distended upto the level of the umblicus and was tender.

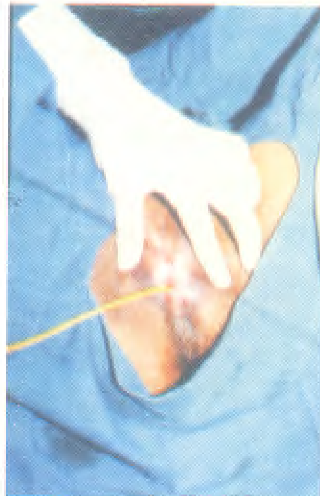
Local examination revealed complete fusion of labia majora and minora. Urethral and vaginal orifices could not be seen (Photograph 1).

In the OPD, Foley's catheter was inserted to relieve her symptom. Labia were gently separated, in that process one orifice was visible and the catheter was passed, assuming it to be the urethra. Urine came out through the catheter and Foley's bulb was inflated. But only part of urine around the catheter was drained and there was leakage of urine through that orifice. So possibility of false passage through the bladder was thought of and the patient was taken to the operation theatre for examination under anesthesia.

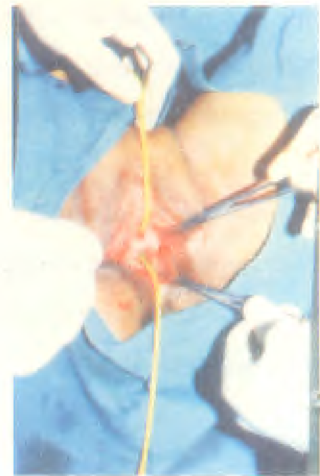
Under general anesthesia, labial adhesions were manually released. After separating the labia, the Foley's bulb was seen inside the vagina and the vagina contained minimal quality of urine (Photograph 2). There were raw, inflamed areas with slightly blood-tinged discharge over labia and vagina. The urethral orifice was separate and second Foley's catheter was passed through the urethral orifice and the urine completely drained out (Photograph3).



Photograph 1. Complete fusion of vaginal orifice



Photograph 2. Catheter inside the vagina



Photograph 3. View after separating the adhesions

Even though the first catheter was inside the vagina, it was draining urine due to dribbling of urine from the external urinary meatus into the vagina (vagina was like a second bladder) because of fused labia.

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She was treated with antibiotics and estrogens locally and orally. She came for check up after one month and was perfectly fine and passing urine without any problem.

Discussion

Senile vaginitis is comparable to vulvo-vaginitis in children. As a result of estrogen deficiency, vulval and vaginal epithelium become thin and atrophic, the glycogen content and acidity of vagina are lowered and the ever present mixed pathogens obtain a footing. The raw, inflamed areas may become adherent and may produce obliteration of the entire canal[1].

Atropic vaginitis can be treated with topical estrogen vaginal cream; use of 1 gm of conjugated estrogen cream intravaginally each day for 1 to 2 weeks gradually provides relief[2]. Systemic estrogen replacement therapy should be considered to prevent recurrence of this disorder. Vaginal resistance is quickly restored by giving any estrogen preparation in full dosage for 3 weeks, followed by an interval of 1 week and then repeated if necessary[3].

References

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