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Labial Adhesion Causing Globe Vesicale and Hematocolpos in an Adult Patient: A Case Report

Yetişkin Bir Hastada Globe Vesicale ve Hematokolposa Neden Olan Labial Adezyon: Olgu Sunumu

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ÖZ

Labial adhezyonlar yetişkinlerde nadiren görülür. Bu adezyonlar yetişkinlerde idrar yapmada zorluk, hematokolpos, cinsel işlev bozukluğu ve sekonder amenore gibi çeşitli problemlere neden olabilir. 22 yaşında kadın hasta hastanemiz acil servisine adet görememe, pelvik ağrı, idrar yapamama, vulvada ele gelen şişkinlik şikayetleri ile başvurdu. Daha önce cinsel birlikteliği olmayan hastanın yapılan jinekolojik muayenesinde hematokolposa ve globe vesicaleye yol açan komplet labial adezyon saptandı. 3 günlük topikal estradiol krem tedavisine rağmen hastanın idrar yapmada zorluk şikayeti ve hematokolpos hali devam etmekteydi. Takiben ameliyathane şartlarında adhezyolizis uygulandı. Cerrahi adezyolizis sonrası eksternal üretral meatus ve hymen doğal olarak izlendi. Rekürrens riskinin azaltılması için cerrahiyi takip eden 4 hafta boyunca topikal estradiol krem tedavisine devam etmesi önerildi. Özetle, yenidoğan ve bebeklik döneminde yapılan genital muayeneye ek olarak pubertal geçiş döneminde de rutin genital muayene yapılması akılda tutulmalıdır. Çünkü, bebeklik ve çocukluk çağında asemptomatik olan olan labial adezyonlar puberteyle birlikte veya yetişkin dönemde semptomatik hale gelebilir.

Anahtar Kelimeler: Cerrahi tedavi, hematokolpos, labial adezyon

ABSTRACT

Labial adhesions are rarely observed in adults. It could cause a variety of problems such as urination difficulties, hematocolpos, sexual dysfunction and secondary amenorrhea in adults. A 22 years old woman admitted to our emergency ward with complaints of secondary amenorrhea, pelvic pain, restricted urination, and vulvar hump. In her gynecological examination, a complete labial adhesion which causes globe vesicale and hematocolpos was detected. Despite three days duration of medical treatment with topical estradiol cream, labial adhesions persisted and a surgical adhesiolysis procedure was planned for further treatment. In order to decrease the risk of recurrence, topical estradiol cream application was recommended for four consecutive weeks after the operation. As a conclusion, a routine genital examination should be born in mind performed during pubertal transition in addition to neonatal, infancy and childhood period as a routine part of a physical examination because asymptomatic adhesions may become symptomatic in puberty and adult years**.**

Key Words: Hematocolpos, labial adhesion, surgical treatment

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INTRODUCTION

Labial adhesions are defined as the partial or complete fusion of labium minus or labium majus. They are frequently observed in infants and early childhood and the estimated prevalence of the disease is vary between 0.6% and 5%. The disease has a peak incidence between 13 and 23 months of age.[1] The pathophysiology of the disease is thought to be a consequence of vulvar inflammation due to low estrogenic state. Furthermore, it is rarely observed in adolescents and adults whom estrogen level are higher compared to early childhood. In addition, the causes of the disease are depended to poor perineal hygiene, perineal trauma, recurrent vulvo-vaginitis, vulvar dermatoses like lichen sclerosis, and frequent usage of diapers. Labial adhesions mostly remain asymptomatic until the fusion partially or completely obliterate the external urethral meatus or vaginal orifice. Although topical estrogen creams are used in the conventional treatment of symptomatic labial adhesions, in severe cases with thick adhesions and resistant to medical treatment, manual or surgical separation of adhesions may be considered as an accurate treatment option.
In this report, we aimed to present the management of an adult patient who presented with globe vesicale and hematocolpos due to severe labial adhesion.

CASE REPORT

A 22 year-old women admitted to our emergency ward with complaints of restricted urination, seconder amenorrhea and vulvar swelling. She had no sexual intercourse before and her last menstruation was about forty-five days ago. There was no evidence for the reason of this adhesion such as recurrent vulvovaginitis, vulvar trauma, vulvar dermatoses in her history. In her gynecological examination, we detected an almost complete labial adhesion which obliterates external urethral meatus and vaginal introitus with a small pinhole opening (Figure 1).

Her pelvic ultrasonography revealed normal ovaries, hematocolpos and globe vesicale (Figure 2).

In her laboratory analysis, FSH, LH, E2, PRL, TSH levels were in normal reference levels and serum ß HCG test was negative. After one-week-long topical estriol treatment, a minimal urinary flow was observed and urinary catheterization was unsuccessful, as a result, her complaints get worsened. We decided to perform a manual/surgical separation procedure under sedation. A surgical adhesiolysis was performed by blunt vertical dissections. Afterward, normal appearing vaginal introitus, intact hymenal ring and external urethral meatus were exposed. The mucosal defects on the posterior fourchette sutured with 3.0 vicryl to control bleeding (Figure 3). Normal vaginal and cervical anatomy was observed by vaginoscopy. An appropriate genital hygiene education and topical estrogen cream application was suggested twice in a day for four weeks after the surgery.

The written informed consent was obtained from the patient for the publication of the figures.

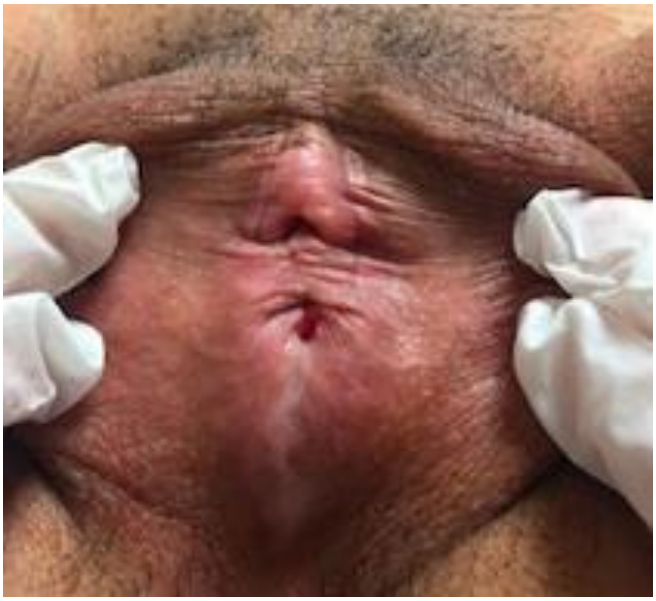

Figure 1. Complete labial adhesion with a pin hole orifis and vulvar bulging.

DISCUSSION

Labial adhesions are rarely reported in reproductive-aged women and the incidence of labial adhesions in adult population has not been defined, yet. Vulvar trauma, perineal injuries after vaginal deliveries, vulvar infections, female mutilation, vulvar lichen sclerosis are known as causes of labial adhesions in adults.[2] Congenital labial adhesions could persist if not diagnosed and treated in infancy and early childhood and may cause severe health problems such as primary or secondary amenorrhea, hematocolpos, hydrocolpos, coital difficulties, difficult urination, urinary retention and recurrent urinary tract infection.[3] Watanbae et al[2] reported that perineal injuries after vaginal delivery are the commen causes of labial adhesions and in some cases the ethiologic factor were unclear in reproductive years.

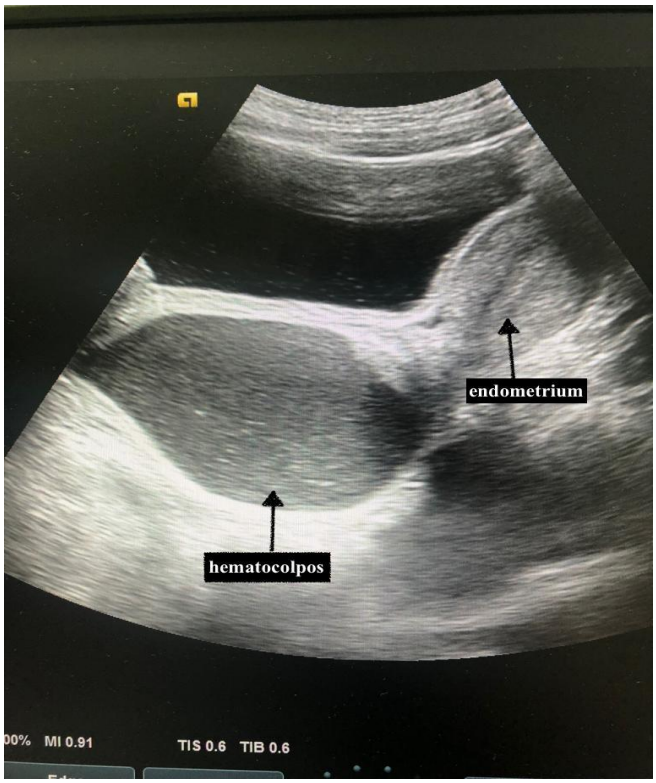

Figure 2. Ultrasonographic view of the hematocolpos and normal uterus in sagittal plane.

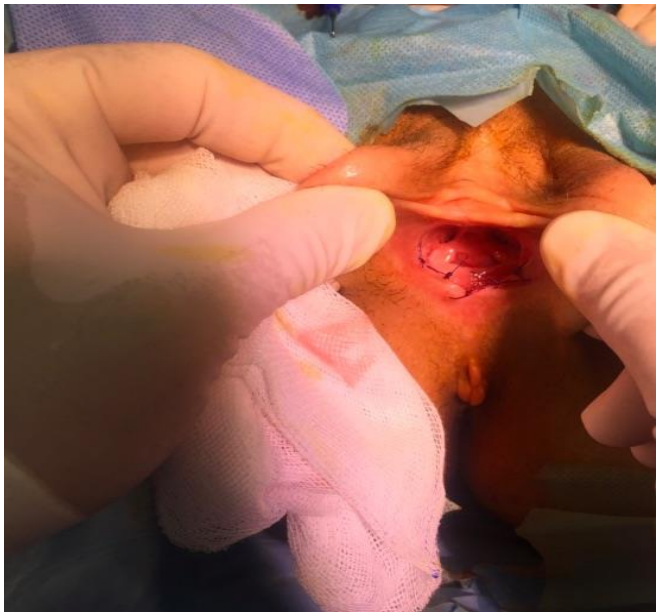

Figure 3. View of the vulvar anatomy after suturation of the mucosal defects.

Topcuoglu et al[4] and Kutlu et al[5] reported the cases of labial adhesion in reproductive age and there wasn't any cause of the adhesion in their cases. Caglayan[6] reported a case of a woman in reproductive age who have labial adhesion after vaginal delivery. In our case, there was no certain cause of adhesion and we thought that the patient had an untreated, gradually expanding congenital labial adhesion, that causing complete vulvar obstruction as a result. Usually, congenital labial adhesions are known to be resistant to topical estrogen treatment.[5] In our case, topical estrogen treatment was not successful and the thick adhesions were treated by blunt dissection under general anesthesia successfully.

The recurrence of labial adhesions after the treatment is quite often and varies between 7% to 55% in the literature.[1] To deal with the high risk of recurrence topical estrogen treatment and appropriate perineal hygiene is highly recommended.[1] During surgical or manual separation approach mucosal defects that leading recurrence could occur and these defects should be repaired meticulously, with absorbable sutures.

In conclusion, a genital examination should be performed during pubertal transition in addition to neonatal, infancy and childhood period as a routine part of a physical examination. Thus, asymptomatic labial adhesions can be detected and patients and parents are given information before it became symptomatic.

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