

Accidental Placement of a Vaginal Mould into the Urinary Bladder

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Citation

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Abstract

Although the bladder is an inaccessible organ, various types of foreign bodies have been removed from it. A 20-year-old married female, who underwent vaginoplasty, accidentally placed the vaginal mould into the bladder per urethra. The vaginal mould was removed from the bladder under anesthesia. The vaginal length was normal. Vaginal mould in bladder has not been reported earlier.

INTRODUCTION

Maldevelopment of mullerian duct occurs in a variety of forms, Disorder of vertical fusion are due to fault in junction between down growing mullerian ducts and the up growing derivative of urogenital sinus. This disorder is characterized by an atretic portion of vagina that can be quite thick, extending through more than half the distance of the vagina, or can be quite thin and limited to a small obstructing membrane. They usually present with symptom due to hematocolpos, cyclic abdominal pain with no menstrual discharge and gradual development of a central abdominal and pelvic mass [1]. Surgery involves dissecting the space between the bladder anteriorly and rectum posteriorly up to the level of septum which is then excised. A vaginal mould is then used to maintain patency of the neovagina.

Various foreign bodies removed from bladder are intrauterine contraceptive devices, filshie clips, mesh used for hernia repair, pocket batteries and knotted electric cables [2-3]. We report the first case in which a vaginal mould was removed from bladder.

CASE REPORT

A 20 year old married female presented to us in emergency with inability to remove the vaginal mould she had inserted the previous day and incontinence of urine. This patient had presented to us 3 months earlier with complaints of cyclic pain abdomen, primary ammenorhea and pain abdomen. She was married for last two years and had no coital difficulty. At that time on examination under anesthesia, the urethral opening was found to be patulous and admitted one finger.

The hymen and urogenital sinus were not developed. Perineal length was normal. On per-rectal examination a bulge in the upper part of vagina was felt about 3 cm from anal opening. Ultrasound showed fluid with internal echoes in the uterus, no adnexal mass and other abdominal organ appeared be normal. An excretory urography revealed good excretory function in both kidneys except for mild hydrohephesis in right kidney due to the enlarged uterus. MRI report suggested the possibility of atretic vagina with hematometra. Vaginal reconstruction was performed. A transverse vaginal septum (1.5 cm thick) was encountered in the upper 1/3rd of vagina, which was excised and released about 1 litre of dark coloured blood. A vaginal mould covered with amnion was introduced to maintain patency of the vagina. The mould was covered with amnion so as for better epitheliasation. The amnion was obtained from the placental membranes. The patient was discharged after two weeks when she was comfortably able to introduce and remove the mould herself. On follow-up one month later, vaginal length was normal and urethral meatus was patulous. Three months later she presented in the emergency department with impaction of mould and incontinence of urine. Per vaginal examination confirmed the patency of vagina, normal cervix and uterus. The mould was felt anteriorly in the bladder on abdomen-vaginal examination. Under general anesthesia (3' x 1½') acrylic resin mould was removed intact from the bladder through the urethra. A self-retaining catheter was introduced. The patient was taught to reintroduce the mould under supervision and discharged after catheter removal and incontinence of urine subsided. We await her next visit hoping an uneventful outcome.

Figure 1

Figure 1- Acrylic resin Vaginal Mould removed from urinary bladder



-DISCUSSION

Transversal vaginal septum is a disorder of vertical fusion between mullerian duct component and the urogenital sinus portion of vagina. Incidences vary from 1 in 2,100 to 1 in 72,000 [1]. It is less common than congenital absence of

uterus and vagina. This results in a transverse vaginal septum in the upper, middle and lower parts of vagina with a frequency of 45%, 35% and 19% respectively. In contrast to mullerian agenesis it is associated with few urogenital or other anomalies.

The patient in the present case at the initial visit presented with urethral dilatation which could be due to sexual intercourse through urethra as the vagina was blind and the patient had no coital difficulties, though an extremely rare presentation. The introduction of mould into the bladder through the urethra was possible because of previous urethral laxity. However, with repeat training to the patient we wish her not to reintroduce the vaginal mould in bladder, which could be of serious consequences later.

References

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