Coitally Related Vagina Injury In A Woman In North Central Nigeria

S Hembah-Hilekaan, I Pam

Citation

S Hembah-Hilekaan, I Pam. *Coitally Related Vagina Injury In A Woman In North Central Nigeria*. The Internet Journal of Sexual Medicine. 2010 Volume 2 Number 1.

Abstract

The true incidence of coital injuries is difficult to ascertain. A report from Calabar, Nigeria showed 0.7/100 gynecological emergencies while, 32 and 30 cases per year were mentioned in reports from Dakar, Senegal and New York, USA respectively. Vagina injury due to coitus remains one of the most common causes of non-obstetric trauma to the female genital tract in the non virginal womanSome of the predisposing factors to coital injuries include intercourse during pregnancy and peurperium, after gynecological surgery and at menopause.The associated problems with coital injuries are those of lack of disclosure and late presentation especially in religiously and culturally closed societies. Practicing physicians and Gynecologists should develop a high degree of suspicion and institute prompt and efficient intervention measures when faced with similar circumstances.

INTRODUCTION

Obstetric trauma to the female genital tract remains the most common cause of injury, yet non-obstetric trauma in this area is not uncommon. The most common mechanism of non-obstetric injury to the vagina is coitus[1]. Although trauma at sexual intercourse remains an everyday occurrence, most are minor and manifest as self-limiting injuries with minimal vaginal bleeding, requiring no medical attention[2]. Women with significant coital injuries may present late and with significant blood loss. This delay may be due to embarrassment because of the nature and cause of injuries or fear of spousal or parental knowledge. Partner abuse should be considered as a cause of injury and appropriately evaluated[3].

We present a case of coitally related injury in a postmenopausal lady in a culturally and religiously closed society, where sexual relationships are hardly ever discussed and use of alcohol almost a taboo; as a reminder to all physicians and Gynecologists practicing in similar localities to develop a high degree of early suspicion for prompt intervention when faced with similar problems.

CASE REPORT

A 58-year old, Para 7, 6 years postmenopausal woman whose husband was late, presented to the gynecological emergency of the Jos University Teaching Hospital, Plateau State in North Central Nigeria, with sharp vagina pain and profuse vaginal bleeding during coitus with her partner. She had earlier had a bout of alcohol at a near by bar in the neighborhood.

On arrival at the gynecological emergency unit of the hospital about 2 hours after the incident, she was found to be apprehensive, with a pulse rate of 80 beats per minute and blood pressure of 100/70 mmHg, pallor was moderate. The main findings were in the pelvis with scanty pubic hair and atrophic vulvo-vagina and continuous oozing of fresh blood from the vagina. On removing the pack, clots of blood and a posterior vagina fornix laceration of about 4cm in semi-lunar fashion was observed extending from the 4 o'clock to the 8 o'clock positions involving the vagina wall and the deep underlining structures.

She was counseled, the vagina repacked and she was taken to the theatre for examination under anesthesia after which the laceration was primarily repaired with interrupted chronic catgut 2-0 sutures. Good haemostasis was achieved and a digital rectal examination was done to ensure that the rectal mucosa was intact. She was transfused two units of cross-matched group O positive blood (haematocrit on admission was 25%). She was also placed on antibiotics (broad spectrum) and analgesics. She was discharged home on the fifth day without complications. Her review four weeks later in the outpatient clinic showed satisfactory healing and she was advised to wait for a further four weeks

before resuming coitus.

DISCUSSION

Although coitally related injuries are very common, non-virginal patients with vaginal injuries as a result of normal sexual intercourse unrelated to criminal assault constitute quite a small but very important group in gynecological practice[4] worldwide. The incidence rate of coital injuries was 0.7/100 gynecological emergencies in Calabar[2], 32 cases and 30 cases of vaginal injuries per year in Dakar, Senegal and New York, USA respectively[5]. Non-obstetric vaginal lacerations can span a continuum of severity from minor trauma as a result of normal coitus to major vaginal injuries. The true incidence of these injuries are sometimes difficult to ascertain, especially because of nondisclosure of the true nature of the injury, due to embarrassment, fear and sometimes religious and cultural inhibitions as may be seen in some communities as exemplified in this case.

Our patient presented with laceration of the posterior fornix which is the most common site of vaginal injuries during coitus. Other sites include right fornix, left fornix and lower vagina with occasional involvement of the posterior vagina wall[5]. The common predisposing factors to coitally related vagina injuries include rough coitus, first sexual intercourse, penovaginal disproportion seen premenarchially and after menopause; use of aphrodisiacs as vagina lubricants, peurperium and inadequate emotional and physical preparation of women for sexual intercourse. Several theories have been postulated to explain the mechanism of injury ranging from vaginal muscular spasm leading to shortening and narrowing, unusual stretching from disproportion, a seasonal variation (seen more in spring and at onset of summer when sexual impulses are stronger). It is however, well established that, intercourse during pregnancy or at peurperium or after gynecological surgery and menopause is more likely to be associated with vaginal injury[4]. This was a postmenopausal woman who was involved in alcohol consumption with her young partner thus making her vulnerable to sexual injury.

The main presentation is usually that of sudden onset of vagina pain accompanied by profuse bleeding, which if not quickly arrested will result in fatality. A quick and efficient diagnosis will require a high index of suspicion by all attending physicians followed by prompt and good physical examination including examination under anesthesia (EUA) under adequate lighting. Prompt patient resuscitation, vagina tamponading and repair of the laceration in theatre is required to reduce morbidity and possible mortality sometimes associated with this condition, especially in culturally and religiously restrictive societies such as ours.

References

1. Fallat ME, Weaner JM, Hertweck SP, Miller FB. Late follow-up and functional outcome after traumatic reproductive tract injuries in women. Am surge 1998; 64:858-861. (Medline).
2. Abasiattai AM, Etuk SJ, Bassey EA, Asuquo EE. Vaginal injuries during coitus in Calabar: a 10-year review. Niger Postgrad Med J. 2005; 12 (2): 140-4
3. Sloin MM, Karimian M, IIbeigi P. Non obstetric Lacerations of the vagina. JAOA. 2006 (106 (5): 271-273.
4. Smith NC, Van Coeverden De Groot HA, Gunston KD. Coital injuries of the vagina in non-virginal patients. SAfr Med J. 1983; 64: 746-747.
5. Ijaiya MA, Mai AM, Aboyeji AP, Kumanda V, Abiodun MO, and Raji HO. Rectovaginal Fistula Following intercourse: a case report. Annals Afr Med. 2009; 8(1): 59-60.

Author Information

SK Hembah-Hilekaan

1. Department of Obstetrics and Gynecology, College of Health Sciences, Benue State University

IC Pam

1. Department of Obstetrics and Gynecology, Jos University Teaching Hospital