MERIT RESEARCH JOURNALS
www.meritresearchjournals.org

Merit Research Journal of Medicine and Medical Sciences (ISSN: 2354-323X) Vol. 10(10) pp. 241-243, October, 2022
Available online http://www.meritresearchjournals.org/mms/index.htm

DOI: 10.5281/zenodo.7242420

Case Report

Unexpected Massive Perineal Destruction Following Consensual Coitus: A case Report

Gaafar Abdulrahman[1], Ibrahim Ismail M. Abu[2*]

[1]MD, FMAS and DMAS. DIRMAS . Consultant in Obstetrics and Gynecology, Assistant Professor, University of Al Fashir, Faculty of medicine, Al Fashir, Sudan

[2]MD, Applied epidemiology fellowship. MPH. Associate professor, Faculty of Medicine, King Abdelaziz University, Jeddah, Saudi Arabia

***Corresponding Author's Email: burha75@gmail.com**

Abstract

Vigorous sexual penetration with penovaginal disproportion may result in severe vaginal injuries that may require prompt surgical intervention. Sexual activity is a common cause of vaginal tears with variable degrees. Vaginal tears could be caused by penis, fall in a sharp object, finger or another object that a person inserts in the vagina causing damage to its delicate tissues, particularly in presence of other predisposing factors. We intend to describe and manage this unusual and interesting case of vaginal tears following consensual coitus. The undue force of the penis creates a tunnel between the anterior wall of the rectum and vagina leading to disruption of external anal sphincter with severe bleeding and fecal incontinence. Subvaginal tunnel was obliterated by interrupted stitches repair. External anal sphincter sutured by end to end anastomosis technique. No acute or short-term complications.

Keywords: Coital, Disruption, Genital tract, Perineal, Laceration, Vaginal

INTRODUCTION

Genital tract lacerations are common and caused by obstetrics and non-obstetric causes. Coital lacerations are non-obstetric causes which could be major or minor. In minor genital laceration which involves vaginal and perennial skin healed spontaneously. But major one is life-threatening condition and requires prompt surgical intervention which has deep extension to muscles and anal sphincters, also some injuries disrupt the posterior vaginal wall and the pelvic peritoneum leading to peritonitis or herniation of small bowel typically after vaginal hysterectomies (Fletcher et al., 2013). The consensual coital lacerations also associated with social and future psychosexual impacts. Predisposing factors to postcoital vaginal tears include rough coitus, first sexual intercourse, penovaginal discrepancy, and use of food or drugs that stimulate sex drive and functions (aphrodisiacs) in different preparation such as vaginal lubricants, period of puerperium, and lack of excitement and preparation of female genitalia for sexual intercourse (Boraiah et al., 2012). Prompt recognition and effective intervention is paramount to prevent acute and long term complications.

Case Report

A 21 year old nonporous, newlywed girl came to the private gynecology clinic with her mother and another relative, suffering from vaginal bleeding and perennial pain which precluded her from sitting on her buttocks for 5 days. She denied initially any relation to coitus, but later in history, she has stated that this happened on the first day of her wedding and she did not seek any medical care, because of embrace and believes that bleeding was normal as her friends told her. No insertion of sex toy or any other object was reported. On physical assessment, she was pale, hypotensive and tachycardic. Abdominopelvic palpation was normal and no tenderness. At perineum, there was type one female genital mutilation (removal of clitoris and removal of

labium minora), then there were clots in the vagina with large cutting on the perennial body and hematoma with tenderness which prevent assessment for the depth of the wound. Patient and her relatives informed and counseled about the initial findings and planned for assessment under anesthesia and then to be managed accordingly. In operating room, there was severe bleeding after removal of clots and there was sharp cutting on the posterior vaginal orifice and perennial body, creating a large tunnel ,extending up to 6 cm beneath vaginal wall and anterior to the rectum with sparing pelvic peritoneum and rectal mucosa, where forced sexual penetration has occurred. Per rectal examination, anal tone decreased and also the external anal sphincter has been damaged by more than 50% of thickness and intact internal anal sphincter. Under good light, the surgical field was cleaned by normal saline 0.9% and clots removed out. The posterior vaginal wall incised vertically to explore bleeding sites at the tunnel and secured. Then, 6 interrupted stitches were taken at the tunnel under vaginal skin, which obliterates the false created cavity. The vaginal skin was sutured continuously by vicryl suture, size 2/0. External anal sphincter sutured by vicryl, size 1, using end-to-end anastomosis. And finally the perineum sutured in a subcuticular manner by vicryl suture, size 2/0. Patient hospitalized for 4 days on intravenous broad-spectrum antibiotics, laxative, soft food and good analgesia.

After 2 weeks postoperative follow-up, she had no complaints and the sutured sites were healed completely, no infection, continent anus over flatus and feces and adequate vaginal space. Later after 6 weeks postoperative, she was okay and allowed to resume her sexual activities with suitable counseling about importance of foreplay, using external sexual lubricants and comfortable sexual positions.

DISCUSSION

In this case where the consensual coital lacerations extends up to 7 cm and creating a tunnel posterior to the vaginal wall and rupturing of the external anal sphincter with severe bleeding, which is unusual to reported cases of coital lacerations. Presence of some factors in our case may contribute to the injuries such as virginity, inadequate foreplay and no use of vaginal lubrication and traditional social habits that believe in presence of blood to prove virginity and maleness of the husband in the first day of wedding and inadequate psychophysical preparation for penetrative sex. The common types of consensual coital laceration include posterior vaginal wall cuts about 3-5 cm, vaginal vault as reported by Manohar and Kavya Shree and lacerations extending into the peritoneal cavity occur in less than 1% of patients (Ramchandani and Buckler, 2009). Ernest et al, reported a case of vaginal vault laceration per se with herniation of the bowel during coitus, approximately two months after an uncomplicated vaginal hysterectomy. Another type of severe consensual coital laceration consists of severe anal sphincters avulsion and severe bleeding.

Unlawful sexual activity (rape) was the commonest cause for coital vaginal injury and it was more common in nulliparous patients (Abasi et al., 2005). The common predisposing factors to coital injuries include rough penetrative sex , first sexual intercourse, unsatisfied sex positions such as dorsal decubitus position, peno-vaginal imbalance, and use of supplements or food that stimulate sex drive and function as vaginal lubricants or other preparations, and inadequate emotional and physical preparation of women for sexual intercourse (Fletcher et al., 2013; Abasi et al., 2005; Ezechi et al., 2009). Others include female genital mutilation, conditions that change vaginal consistency such as postmenopausal sate, pregnancy, puerperium and previous vaginal surgery (Umaru et al., 2013).

CONCLUSION

Because of embarrassing situations, fear and social stigma some women will come late to seek medical advice and offer inadequate histories of the events, leading to trauma to the vulva or vagina due to vigorous sexual activity. So thoroughly history taken and proper clinical examination are crucial to recognize severe injuries and consider legal dimensions in some circumstances. Rush to operating theatre may be necessary in life threatening conditions, also considering multidisciplinary approach is essential as general surgery in extensive injuries, colorectal surgery in late presentations with anal sphincters damage or previous failed initial gynecologist attempt. Also psychotherapy and psychiatric support are of paramount importance to enhance the Quality of Life. Education and counseling for consensual penetrative sex is of great importance, particularly in high risk patients such as newly married couples, postvaginal surgery, during or recent puerperium, uncomfortable sexual positions and for those using aphrodisiacs.

REFERENCES

Abasi Atta AM, Etuk SJ, Bassey EA, Asuquo EE (2005). Vaginal injuries during coitus in Calabar, a 10-year review. Niger Postgrad Med J 12(2):140-144.

Boraiah S, Sheela SR and Shetty MVK(2012). Post Coital Fourth Degree Recto vaginoperineal Tear: A Rare Case Report. Int J Pharm Sci Res. 3(11); 4372-4373.

Ernest A, Emmanuel M, Gregory K (2014). Post-coital posterior fornix perforation with vaginal evisceration. BMC Womens Health. Nov 25;14:141. doi: 10.1186/s12905-014-0141-6. PMID: 25420670; PMCID: PMC4251674

Ezechi OC, Fasubaa OB, Dare FO (2009). Vaginal injury during coitus at ile Ife: A 16-year review. Nig J Med 9:16-18.

Fletcher H, Bambury I, Williams M (2013). Post-coital posterior fornix perforation with peritonitis and hemoperitoneum. Int J Surg Case Rep 4(2):153-155.

Manohar R, Kavya Shree G (2013). "Post coital vaginal tear - a rare life threatening emergency". Journal of Evolution of Medical and Dental Sciences; Vol2, Issue 40, October 07; Page: 7637-7639.

Ramchandani P, PM Buckler (2009). "Imaging of Genitourinary Trauma." American Journal of Roentgenology 192(6): 1514-1523.

Symeonidis N, Ballas K, Micha A, Psarras K, Pavlidis T (2014). Consensual intercourse resulting in an extensive rectovaginal tear: an extremely rare occurrence. J Sex Med. 2015 Feb;12(2):572-5. doi: 10.1111/jsm.12754. Epub Nov 6. PMID: 25376118

Umaru I, Babagana B, Abdelkarim GM, Ado DG (2013). Coital trauma as seen at the University of Maiduguri Teaching Hospital, Maiduguri. Bo Med J 10(1):25-29.