ACQUIRED GYNAETRESIA WITH CRYPTOMENORRHOEA SECONDARY TO INDUCED ABORTION A CASE REPORT.

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Abstract:

Gynaetresia is the occlusion of some part of the female genital tract especially occlusion of the vagina. It may be congenital or acquired. Acquired gynaetresia with cryptomenorrhoea usually presents with cyclical monthly pelvic or rectal pain but no bleeding per vagina. It may occur as a result of trauma to the female genital tract with secondary infection and adhesions.

We present a case of acquired gynaetresia with secondary amenorrhoea in a twenty year old student of a secondary school in an urban centre, who presented at the gynaecological unit of Armed Forces' Specialist hospital with history of termination of eight weeks pregnancy at a chemist five months prior to time of presentation. Since then she has been having cyclical monthly lower abdominal pain but remained amenorrhoeic. The pain became severe that day hence she presented at the hospital. Findings at the surgery were dense adhesions in the vagina with complete obliteration of the cervix. She had adhesiolysis and cruciate incision and evacuation of about 600 ml of dark brown insipitated blood.

Key words: *Acquired gynaetresia, cryptomenorrhoea, induced abortion.*

Introduction:

Gynaetresia is defined as occlusion of part of the female genital tract especially occlusion of the vagina by a thick membrane[1]. Congenital gynaetresia occurs when there is failure of canalization with resultant partial or complete agenesis, transverse or longitudinal septa while the persistence of the urogenital membrane results in an imperforate hymen. This may be obvious at birth or may present after menarche with features of cryptomenorrhoea, dyspareunia or labor dystocia[2]. Acquired gynaetresia is much less common than the congenital type in the developed world but the converse is the case in the tropics[3]. In the developed countries, when gynaetresia occurs, it is often iatrogenic, following vaginal surgical procedures such as colporrahaphy and hysterectomy, or sequel intra vaginal irradiation in the treatment of gynaecological malignancies[3]. In the developing countries, acquired gynaetresia is a common problem due to some cultural practices, poverty and ignorance[4&5]. Notable among these are vaginal insertion of local herbs in the treatment of a wide range of gynaecological conditions such as infertility, amenorrhoea and in procuring induced abortions. Trauma and infection of the genital tract cause vaginitis with formation of adhesions leading to gynaetresia. Other causes include female genital mutilation and prolonged obstructed labor[6&7].

In congenital gynaetresia, occasionally at birth, an imperforate hymen may cause a mucucolpos due to retained vaginal and uterine secretions. An abdominal mass with a bulging hymen may be present. In the post menarchial period, they would present cryptomenorrhoea secondary to transverse vaginal bands, partial vaginal atresia or imperforate hymen. The patients usually present with cyclical monthly pelvic and or rectal pain but no bleeding per vagina. Continous retention of menstrual flow in the uterine cavity and upper vagina, results in a palpable pelvic mass (haematometra) and or (haematosalpinx) and a tense bulging vaginal cavity

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(haemotocolpos). A pelvic ultrasound would confirm the diagnosis[8]. The management is by cruciate incision of the imperforate hymen in congenital cases with spontaneous evacuation of the characteristic dark brown insipitated blood. In acquired gynaetresia with dense adhesions, more extensive dissection and plastic reconstruction may be required. Cryptomenorrhoea requires treatment as soon as diagnosis is made to relief the abdominal pain and discomfort.

Case report

Miss D. A is a 20 year old para 0+1. She presented to the gynaecological clinic of Armed Forces' Specialist Hospital on 14th of September 2006 with lower abdominal pain of five months duration. The pain has been cyclical every month for the past five months following a termination of eight weeks' pregnancy at a medicine store. The pain became severe on that day hence she decided to seek medical attention. Her last menstrual period was on 5th of March 2006. She had the induced abortion on the 8th of May 2006 by insertion of chemicals per vagina and subsequent evacuation with a syringe like instrument. Since then she had not menstruated but usually has lower abdominal pain and rectal pain every month around the time she used to menstruate. She also had dyspareunia. Her menarche was at 12 years. She menstruates for four days in a regular cycle of 28 days. She had been treated for sexually transmitted diseases before. Clinically she was not pale. Her blood pressure was 100/60 mmHg, pulse rate was 74 beats per minute and was normal. Her heart sounds and breathe sounds were normal. Abdominal examination revealed a suprapubic mass which was approximately compatible with 12 weeks' size pregnant uterus. It was tender and soft. Vaginal examination revealed a normal vulva and the vagina was obliterated with fibrosis. It could only admit a tip of the finger. Rectal examination revealed a uterine mass of about 12 weeks' size and the adnexa were normal. Her haenatocrit was 35%, blood group was O Rhesus positive, retroviral screen and VDRL test were non reactive. Urinalysis was normal. Pelvic ultrasound scan revealed "uterus with a normal AP diameter with echogenic content - ? cryptomenorrhoea". She had examination under anaesthesia, adhesiolysis, incision and evacuation of 600ml of dark brown blood. The specimen yielded no growth on culture. She had prophylactic antibiotics with augumentin and metronidazole. She was observed in the ward for 24 hours and then discharged to gynaecological clinic. She was advised to dilate the vagina with glass rod dilators and apply a lubricant (petroleum gel) for two weeks. She was followed up at the clinic and was doing well. The vagina was capacious with normal sized uterus. She was counseled on family planning options and sexually transmitted infections as well as complications that can arise from such. She is presently on follow up.

Discussion

The acquired gynaetresia with cryptomenorrhoea in this patient was due to chemical vaginitis caused by the chemical inserted to procure the abortion. Unsafe abortion is a commonly neglected reproductive problem in developing countries and yet it posses a serious threat to the health of millions of women during their reproductive lives[9]. Until unsafe abortion and its consequences are eliminated, complications from unsafe abortion will remain a major cause of maternal morbidity and mortality[10]. Unsafe abortion by WHO is termination of an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standard, or both[11]. Unsafe abortion remains a frequently unacknowledged public burden of substantial

proportion. Although most of the women seeking abortion are married or in stable unions and already have several children, an increasing proportion are unmarried adolescents, particularly in urban areas[12]. Such was the case of our patient. Throughout the developing countries, countless women are barred from access to safe abortion services due to combination of social, economic, religious and policy factors[13&14].

Acquired gynaetresia can cause significant gynaecological morbidity. In patients who are married, it can cause marital disharmony because of the dyspareunia as well as infertility[15&16]. This patient had dyspareunia as one of the complaints. In most African communities, childlessness is perceived as failed marriage[17]. This patient also had amenorrhoea, low abdominal pain and a suprapubic mass due to the haematocolpos.

The management was examination under anaesthesia with adhesiolysis and drainage of the haematcolpos. Some people would drain the haematocolpos and then do the vaginoplasty later[18], but in this case, the adhesions were so dense and had to be released to get asses to the cervix to drain the haematocolpos. She had prophylactic antibiotics to prevent infection recurring and she was asked to use glass dilators to prevent further adhesions[19&20].

A number of factors contribute to high levels of unsafe abortions in Africa. There are low levels of contraceptive use, poor quality reproductive health services, restrictive abortion laws that limit the availability of safe abortion services and post abortion care[21].

The ways to reduce unsafe abortions in the region include significant improvement in access to services through implementation of existing abortion laws and polices, decentralization of services and involvement of the private health care sector[22].Urgently needed are improvements in the poor quality of abortion and post abortion services and increase availability of services for adolescent girls who make up a significant proportion of abortion seekers in Africa[23]. Reforming restrictive and punitive abortion laws would reduce maternal mortality and morbidity from unsafe abortion in Africa[24].

Until unsafe abortion is eliminated, women and public health systems will continue to suffer the consequences of abortion performed under unsafe conditions. Unfortunately, safe motherhood programs generally do not address the causes and consequences of unsafe abortion. Consequently, as the other causes of maternal mortality decrease, deaths from complications of abortion increase as a proportion of all deaths.

CONCLUSION: Complications from unsafe abortion are of significant public health concern. Some may cause mild morbid conditions which may subside without much notice but there are some that would last for the women's remaining life span such as infertility and also complications could be severe to result in maternal mortality.

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