Labial Agglutination in an Adolescent Girl

ABSTRACT

We are reporting a case on labial agglutination in a 16-year-old unmarried female who presented with abdominal pain, painful micturition, and altered colored vaginal discharge with passage of tissue debris while urinating since 1 year. She gave history of recurrent per vaginum discharge since more than a year for which she received antibiotics. She was admitted as a case of urinary retention with dysuria and abdominal pain. She was diagnosed as a case of leukoplakia of the vulva and labial agglutination, which is rare in the adolescent age group.

Keywords: Adolescent, Adhesiolysis, Labial agglutination.

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CASE REPORT

A 16-year-old unmarried female with menarche attained 1 year back presented with chief complaints of pain in abdomen with inability to pass urine, pain while micturition, incomplete micturition, bloody vaginal discharge with passage of tissue debris while urinating since 1 year with excoriation of perineal skin. There was no history of nausea, vomiting, fever, application of irritants to perineal skin, difficulty while defecation, abdominal lump, any drug intake, surgical intervention, diabetes mellitus, or immunocompromised status. Menarche attained at 15 years of age with irregular scanty menses every 2 to 3 months lasting for 1 to 2 days. She gave history of recurrent white per vaginum discharge for which she took antibiotics 4 to 5 times. Personal and family history was not contributory.

On enquiring, her mother revealed that the external genitalia were normal at birth and also 1 year back.

General and systemic examination was normal. On per abdominal examination, there was no guarding, rigidity, tenderness, distention, or lump palpable. Local examination revealed leukoplakia of the vulva extending up to labia majora associated with edematous skin. Excoriation of the perineal skin was seen. A small pinpoint opening was noted in the midline with apparent fusion of both the labia without any urethral and hymenial delineation, as in Figure 1. On per rectal examination, normal sized uterus was felt without any mass, bogginess, or nodularity in the pouch of Douglas. So we came to a provisional diagnosis of labial agglutination, most probably due to fused labia.

Routine investigations including urine microscopy were normal. Pelvic ultrasonography showed normal status of uterus and ovaries. No e/o hematometra or hematocolpos. Vagina appeared normal and its end was about 1 cm from introitus © d/t fused labia. Magnetic resonance imaging suggestive of normal-sized uterus and ovaries with minimal fluid collection in vagina. Foley’s catheterization was painful, so under short general anesthesia Nelson’s catheter no. 10 was inserted by urologist and clear urine 300 cc was drained. Cystoscopy showed normally situated ureteric orifices and normal appearance of bladder neck and external urethral meatus. She was given broad spectrum antibiotics and was posted for labial adhesiolysis and labial reconstruction under spinal anesthesia.

Fig. 1: Fused labia
Labial Adhesiolysis and Labial Reconstruction

Written informed consent taken from parents.
Retractors introduced through pinpoint opening. Separate urethral and vaginal opening seen. Vertical incision taken over fused labia (Fig. 2). Visualized cervix appeared healthy. Biopsy from leukoplakic skin taken. Labial edges everted and labial reconstruction done with interrupted Vicryl no. 1-0 to prevent refusion (Fig. 3).
Postoperative intravenous antibiotics, framycetin sulfate cream, sitz bath, and perineal care given. Histopathology report of skin biopsy was normal dermis, epidermis, and appendages. The patient was discharged on postoperative day 7 and was advised sitz bath and local application of cream at home. On follow-up after 4 weeks (Fig. 4), local examination showed normal appearing perineum without any inflammation, infection, or discharge.

DISCUSSION

Labial fusion is most common between the ages of 13 and 23 months, with incidence of 3.3% in this age group.\(^1\) It is estimated that labial fusion occurs in 0.6 to 5% of all prepubertal girls.\(^2\) It is rare in adult women but is occasionally found in postpartum and postmenopausal women.

Labial fusion is caused by inflammation which on progression leads to activation of macrophages destroying cells proximal to the site of inflammation. Body repairs the damaged epithelium by new collagen synthesis which progresses to fibrosis and eventual scarring.\(^3\)

Causes: Low estrogen level, vulvitis, application of irritant to perineal skin (bubble bath, harsh soap), Urinary tract infection (UTI), trauma, sexual abuse, female genital mutilation, diabetes mellitus, immunocompromised status, and surgical intervention.\(^4,5\)

Thus, this is a case of partial labial agglutination, probably due to recurrent vulvovaginitis managed successfully surgically.

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