ABSTRACT

Secondary cryptomenorrhea is a rare disorder and results due to adhesion formation postdelivery and puerperal sepsis. We report such a case who presented as amenorrhea and progressive pain in the abdomen postdelivery.

Keywords: Puerperal sepsis, Secondary cryptomenorrhea, Vulvo-vaginal stenosis.


INTRODUCTION

There can be many causes of secondary amenorrhea, but vaginal and cervical atresia postdelivery is a rare cause in today’s world and results due to unskilled health personnel managing pregnant women in rural areas. Gynatresia, which is acquired, is less common than the congenital type. The causes are often iatrogenic following vaginal surgical procedures like colporrhaphy and intravaginal radiation or puerperal sepsis and illegal abortions. Trauma causes adhesions and blockage of outflow tract leading to hematometra.

CASE REPORT

A 25-year-old P1L1 presented with a history of amenorrhea and pain in the lower abdomen since the last childbirth. She had delivered at home, with the help of a midwife. It was spontaneous vaginal term delivery, and she gave a history of prolonged labor and puerperal pyrexia. She had no urinary or bowel complaint. She gave a history of hematometra drainage by exploratory laparotomy in a private hospital 1 year back for similar symptoms.

Examination

The patient was thin built, afebrile, with mild pallor and mild hirsutism; breast and thyroid were normal with normal findings on general physical examination. Her systemic examination was normal. On abdominal examination, vertical infraumbilical scar of previous surgery and previous drain site were identified on the left side. The uterus was enlarged symmetrically to 14 to 16 weeks’ size (Fig. 1), with tenderness on palpation. On per speculum examination, cervix was absent, vault seemed to be blind, there was darkening of the vault, and no cervical opening was seen. On per vaginal examination, the same mass that was palpable abdominally was also felt through P/V. On P/R examination, the same findings were elicited. So, a provisional diagnosis of hematometra secondary to cervical stenosis postdelivery was made. Ultrasonography of the abdomen and pelvis was done; however, report suggested the diagnosis of bulky uterus with hematometra (Fig. 2). Examination under anesthesia was attempted to drain the hematometra vaginally but was unsuccessful. Therefore, after consent for hysterectomy, a laparotomy was planned. It was decided that an attempt for conservation of fertility would be made if possible. The patient was prepared for exploratory laparotomy. Intraoperative findings were as follows: Uterus enlarged symmetrically to 16 weeks, omental adhesion present all over the uterine surfaces, bladder was densely adherent to the uterus, B/L tubes and ovaries were present as one single tubo-ovarian mass.
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and this was adherent to posterior uterine surface and bowel, so that the pouch of Douglas was blocked. During the course of hysterectomy, B/L vault angle was ligated and the vault was sounded by a dilator, but no opening was appreciated. Therefore, the vault was approximated over this blind space in the continuous interlocking fashion. Postoperative recovery was uneventful, and the patient went home on the 10th postoperative day.

DISCUSSION

Puerperal sepsis can silently lead to cervical and vaginal stenosis as in this case, leading to secondary amenorrhea and hematometra. A search of the literature revealed few reports on vaginal atresia. Singhal et al\(^2\) reported a posttraumatic vulvovaginal stenosis in a 24-year-old woman following perineal injury 10 years back due to fall from the staircase. She was treated by modified McIndoe operation. Similarly, Rutgers et al\(^3\) reported a 19-year-old girl with secondary amenorrhea due to vaginal stenosis due to foreign body (plastic mouthpiece of child’s trumpet), which was successfully treated by a Z-like incision on the septum and the vagina was reconstructed with Z graft. Omale’s team\(^1\) reported a 20-year-old student presenting with a history of termination of 8 weeks’ pregnancy by insertion of chemical per vaginum and subsequent evacuation with a syringe-like instrument 5 months prior. Since then she had cyclical monthly lower abdominal pain but remained amenorrheic. Examination revealed dense adhesions in the vagina with complete obliteration of the cervix. She had adhesiolysis and cruciate incision and evacuation of altered blood. Frith\(^4\) reported four cases of vaginal atresia in Arabia. From the 5th to the 12th day of puerperium, balls of rock salt were placed in the vagina to shrink it back to the nulliparous state, causing chemical vaginitis, leading to adhesions and perivaginal fibrosis. In the long term, it causes infertility, obstructed labour, hematometra. These were treated by simple adhesiolysis.

CONCLUSION

Puerperal sepsis can infrequently lead to rare complications like cryptomenorrhea. Hence, all delivery should be institutionalized to avoid such morbid complications.

REFERENCES