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Non-Obstetrics Vaginal Lacerations from Consensual Coitus: A Case Series

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Abstract

Consensual coital lacerations are commonly encountered in clinical practice, though not as common as lacerations sustained during childbirth, they account for significant morbidity and occasional mortality among sexually active women. Sexual intercourse which is consensual should ideally not cause any form pain or injury as opposed to rape. When minor injuries occur, it usually resolves with minimal or no intervention. Occasionally, severe coital lacerations may occurs and they are usually deeper and more extensive resulting to life threatening blood loss, which can result in morbidities and in rare cases, mortalities. Coital laceration commonly results from inadequate foreplay prior to penetration leading to non-lubrication of the vagina. Coital injuries are unlikely to be reported or may be misdiagnosed and eventually mismanaged.

The authors reported their experiences in the management of patients with coital laceration, the mechanism of injury and associated risk factors were also highlighted. The authors presented five cases.. All five patients were not adequately lubricated prior to penetration due to inadequate foreplay. All were consensual and were either with their lovers or the spouses. None of them was circumcised or had had any form of genital mutilation.

These case series bring to front burner the common mechanism of injury in consensual coital laceration, common anatomical location of injury and the need for clinicians to have high index of suspicion when reviewing sexually active women with history of vaginal bleeding, as the history might be grossly inadequate and misleading due to socio-cultural stigma. Timely diagnosis and prompt intervention, which may require surgical repair, can be live saving.

Keywords: Non- Obstetrics; Vaginal; Lacerations; Consensual; Coitus; Shock

Introduction

Consensual sexual intercourse should ordinarily be a pleasurable activity to both partners [1]. However, in some cases injuries ranging from self-limiting minor vaginal injury such as bruises with minimal bleeding, which do not require medical attention to life threatening tear with severe bleeding could ensue. This severe bleeding could progress to haemorrhagic shock and death if not promptly managed. Consensual coital injuries are not uncommon in gynaecological practice, yet available data are relatively scarce [1-3].

This might be due to the fact that sex is seen as shameful topic to be discussed and taboo in extreme cases. Complaints regarding coital injuries could also be perceived as shameful as a result of cultural stigmatization associated with sex related issues in our environment [1,2]. Consensual coital injuries are most likely underreported especially when the injury is minor [3]. However, some of the major and life threatening consensual coital injuries do present to the hospital for care, but early diagnosis and prompt management may be challenging due to cultural factors and limited experiences by care givers [2,3]. The true incidences of consensual coital injuries are difficult to ascertain, especially because the nature of vaginal injury usually remains undisclosed [2]. Some authors had reported incidence ranging from 0.34% to 0.7% of all gynecological cases in Nigeria [4]. The scarcity of data

on this subject underscores the need for this case series to create awareness especially with the decline age at first sexual debut (coitarche) and add to the body of knowledge

Case Series

Presented here are five patients with consensual coital vaginal lacerations who presented and were managed by the authors. Three of the patients presented in hypovolaemic shock. None of them was circumcised or had any form of genital mutilation.

Case 1

A 18 year old P_0+^0 young lady, who sustained a deep transverse laceration about 4cm in length and 2cm in depth on the posterior fornix of the vagina with other minor bruises on the lateral vaginal walls. She presented eight hours after onset of bleeding in hypovolaemic shock. She sustained the injuries while having consensual sex with her boy friend. She was said to have been placed in the missionary position during the intercourse. There was no adequate foreplay prior to penetration.

Case 2

A 17 year old P_0+^0 single undergraduate student, who had a deep longitudinal laceration on the posterior fornix extending to the mid vagina. The laceration measures about 5cm in length and 2cm in depth. She presented to the hospital six hours after onset of vaginal bleeding in hypovolaemic shock. This was her first sexual debut with her first boyfriend, who was equally having sex for the first time. Foreplay was not adequate and she was not properly lubricated as the act was done in a hurry to avoid being seen by friends.

Case 3

A 32 year old nulliparous newly married woman. She had a deep laceration about 2cm on the right posterior-lateral wall of the vaginal. She presented one day after onset of bleeding in stable clinical condition. She was having consensual sex for the very first time with her husband, who incidentally is having sex for the first time. She thought the bleeding was from the hymen and only presented when it persisted. There was no adequate foreplay.

Case 4

A 53 year old P_1+^0 (1 A) married two years postmenoupsal woman who sustained a deep transverse laceration about 4cm in length and 1.5cm in depth on the anterior wall of the vagina. She presented twelve hours after onset of bleeding in stable clinical condition on initial assessment. She sustained the injuries following consensual intercourse with her husband who was on treatment for erectile dysfunction and was placed on slidenafil (Viagra). There was no adequate foreplay as the husband hurriedly penetrated as he achieved some level of erection.

Case 5

A 24 year old P_0+^1 single lady who had a deep longitudinal laceration measuring about 5cm in length and 2cm in depth on the posterior fornix of the vagina. She presented to the hospital three hours after onset of vaginal bleeding in hypovolaemic shock. She has not had sex for two years because her soldier boyfriend had been away on a united nation peace keeping mission. She sustained the injury while having consensual sex with him on his return. Foreplay was not adequate and she was not properly lubricated.

Treatment

The first, second and the fifth patients presented with hypovoleamic shock, thus they required aggressive fluid resuscitation and blood transfusion to reverse the hemorhagic shock. All the patients were promptly prepared for examination under general anaesthesia in the theatre. The lacerations were repaired primarily with vircyl 0 suture in continuous interlocking fashion to secure haemostasis. All the patients had digital rectal examination to ensure that the rectal mucosa was not involved in the laceration as well as ensuring that the rectum was suture free. The bladder and urethra were also examined to rule out urinary tract injury. The three patients that presented in hypovoleamic shock were transfused with two to three units of blood depending on the degree of shock. The packed cell volume for all the patients post operatively was adequate. The other two patients that were clinically stable were placed on oral haematinics meanwhile all the five patients were prescribed broad spectrum antibiotics. The 3 single undergraduate students were placed on emergency contraceptives and further adviced on use of barrier contraceptive whenever they want to engage in sexual intercourse in the future. The role of adequate foreplay was reiterated to all the patients. They all had satisfactory immediate postoperative period and were discharged home within twenty four to forty eight hours with no complications.

Discussion

Non-obstetric laceration of the vaginal wall following introitus is a usual occurrence, though under-reported in our environment, particularly during coitarche [1,5]. It can vary from minor self-limiting minimal vaginal bleeding, which do not require medical attention to life threatening tear with severe bleeding which could progress to haemorrhagic shock and death if not promptly managed [1-3]. This was the situation in our first, second and fifth cases. They all presented with haemorrhagic shock. The true incidence of such injury is difficult to ascertain, especially because the nature of vaginal injury usually remains undisclosed. The low incidence may be related to the shame and secrecy attached to the condition which makes most cases to linger in silence and only a few severe cases and those related to rape cases reported to the hospital for medical attention [1]. Our third and fourth did not present early due to shame [1,2].

Coital laceration may involve single or multiple sites. The right side of the posterior fornix is the most frequently affected

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site, others areas such as the vagina vault and the clitoris might also be involved seldomly. The posterior fornix is the part of the vaginal that receives the penile thrust during intercourse. It has been reported that the endopelvic fascia of the posterior fornix is weak thus the predisposition to injuries [6]. Other reporters had implicated the dextrorotation characteristics of the uterus, which is thought to cause the distensibility of the vagina in this area [6]. The vagina prepares itself for penile penetration by adequate lubrication during sexual desire. Inadequate lubrication of the vagina before coitus reduces the vagina elasticity especially in the posterior fornix. It is probable that where such changes occur, injuries during coitus would not result. All the patients in the cases reported did not have adequate foreplay and reported not to be properly lubricated before the penetrative sexual act.

The common predisposing factors to coital injuries include nulliparity, rough coitus, first sexual intercourse, harmful positions such as dorsal decubitus (missionary) position, peno-vaginal disproportion, and use of aphrodisiacs as vaginal lubricant, insertion of foreign bodies, penile jewelry and inadequate emotional and physical preparation of women for sexual intercourse. Other risk factors are increased friability of the vagina associated menopause, pregnancy, puerperium. In some cases, intimate partner abuse should be considered as a cause of injury and this calls for an empthic and systematic evaluation [4,7,8]. The risk factor in the first patient was more of the position she assumed during the sexual intercourse, in the second and third patients it was their sexual debut (coitarche) with inadequate foreplay. The husband of the fourth patient used aphrodisiacs (Viagra), while the last case of lack of adequate foreplay. In fact all the patients above lack the proper readiness for sex and did not have adequate foreplay prior to penetration. The woman with coital vaginal trauma may present late due to embarrassment or fear of spousal or parental knowledge, thus increasing morbidity from blood loss [9,10]. This was seen in case three and four.

Prompt and proper management of this condition is important to prevent complications such as haemorrhage, sepsis, vaginal stenosis, injury to abdomino-pelvic organs, recto-vaginal fistula, vesico-vaginal fistula and death from occurring [3,10]. A rectal examination must be performed in all cases of coital injuries on the posterior vaginal wall to rule out rectal involvement. Unnoticed rectal injury left unrepaired might leads to rectovaginal fistula.[4] All the patients were lucky not to have develop any complication. Management includes resuscitation with intravenous fluid, blood transfusion in severe blood loss and surgical repair of the laceration. This was the line of management for all the patients, three of them with extensive were transfused with blood. Extensive laceration should be repaired with absorbable suture under general anaesthesia [8]. This will enable the base of the tear to be clearly seen in order to exclude involvement of peritoneal cavity [10]. Vaginal laceration with peritoneal cavity involvement is approached through laparotomy where any intraperitoneal organ involved is treated as well.

Conclusion

Coital laceration is not uncommon in gynaecological practice, there is therefore a need for public enlightenment on sexual response and the risk factors associated with coital laceration in order to reduce the incidence. Patient and their partner should be counseled on the importance of negotiating sex and having adequate foreplay as well as correct use of contraceptive. A high index of suspicion, tactful, privacy, empathy and good clinical judgment approach is a necessary requirement for early diagnosis and good management.

Authors Contributions

Patient management: Ojurongbe Olubisi Adegoriola, Fijabiyi Matthew Olusegun, Taiwo William.

Manuscript drafting and revision: Fijabiyi Matthew Olusegun, Ojurongbe Olubisi Adegoriola.

Final editing and proof reading: All the authors .

Conclusion

PAS is one of the conditions that can be regarded as "obstetrician nightmare" because of its attendant severe maternal morbidity and significant mortality. Early identification of patients with risk factors is critical for effective management plan. Management options can be conservative to radical approach depending on several factors. The role multidisciplinary team approach is sine qua non to a favourable feto-maternal outcome with reduction in morbidity and mortality.

Authors Contributions

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