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RESEARCH ARTICLE

LABIAL ADHESIONS–A RARE GYNECOLOGICAL DISORDER

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ABSTRACT

Labial agglutination occurs when the labia minora have fused. These maybe either filmy or dense adhesions and form a raphe in midline.This condition is seen in paediatric population, prepubertal girls and also have been reported in reproductive age group and post- menopausal women. The possible etiology of this may be a hypoestrogenic state which leads to local irritation and inflammation. Here we present two cases – first a 24 years nulligravida, with labial agglutination which was refractory to conservative management. Second case – a 42 years unmarried female with dysuria.

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INTRODUCTION

Labial agglutination occurs when the labia minora have become fused by adhesions and forming a midline raphe. This condition is commonly seen in prepubertal girls and also reported in reproductive age group (Muram, 1999; Norbeck, 1993; Kuo *et al*., 1998). In postmenopausal women fusion develops secondarily may be due to hypoestrogenic state which leads to local irritation and inflammation (Muram, 1999). Other causes may be thinning of the vulval mucosa, poor hygiene, lichen sclerosis, contactwith urine, local infection, and mechanical irritants (Pulvino, 2008). The inflammation may play a key role in the presence of a hypoestrogenic state to cause agglutination (Pulvino, 2008). Labial agglutination is mostly asymptomatic, especially in pre-menarchal girls. When symptoms are present in an older woman, they may include dyspareunia, heamatocolpos, trickling of urine, poor urinary control, urinary tract infections. Rarely associated with pyosalpinx (Pulvino, 2008; Tsianos *et al*., 2011; Chuong *et al*., 1984). In pediatric population fusion usually involves only the labia minora, whereas in postmenopausal women agglutination may also involve the labiamajora (Chuong *et al*., 1984). Severe labial fusion can sometimes leave only a small pinhole through which urine can escape. The urine pooling in vagina with voiding causing urocolpos and subsequent urine leakage from vagina upon standing after voiding. These findings can predispose the patient to ascending infections (Tsianos *et al*., 2011; Chuong *et al*., 1984).

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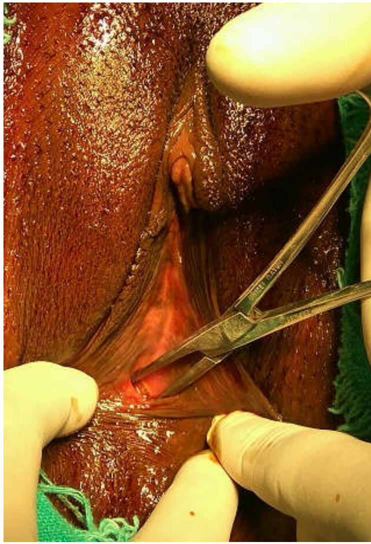
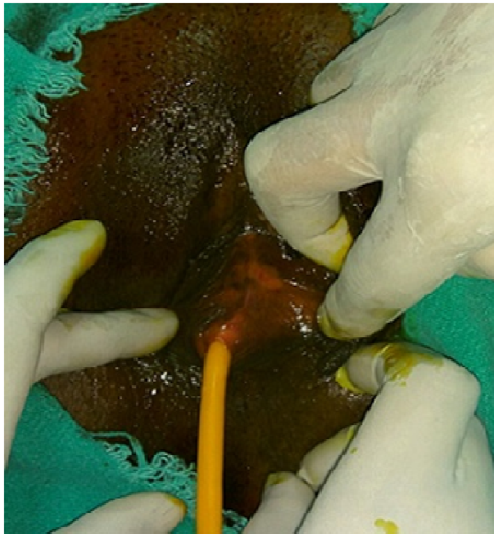
Case report 1

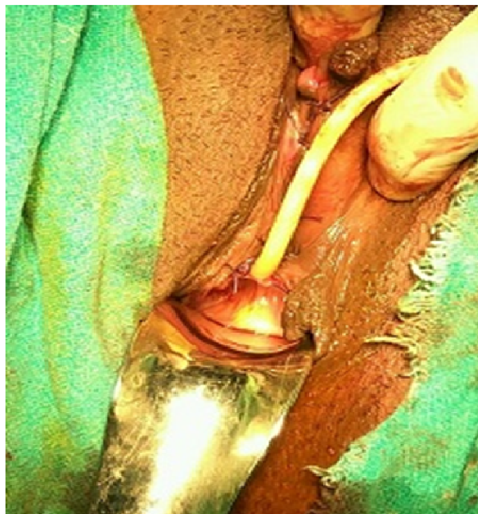
A 24-year-old Northern Indian female attended the OPD for non-consummation of marriage. She had history of fall and genital trauma at age of 8 years for which she had treatment at a local hospital. Subsequently, she developed labial agglutination.She had no complaints after that, however after her marriage she experienced difficulty in sexual intercourse.
Her menstrual history was normal and had no urinary complaint. On genital examination, there was complete agglutination of the labia minora from clitoris to the posterior fourchette. A pinpoint opening was seen nearthe posterior fourchette. The urethra was not visualized. She was examined during menstruation, blood and urine were coming from same opening. There was no cutaneous signs of lichen sclerosis or lichen planus. On rectal examination uterus was palpable and no other findings. Her ultrasonography of pelvic organs, CT scan of genitourinary system and micturatingurocystogram were normal.

The patient was examined under anesthesia.¾ mmHegar's dilator was introduced through introital opening. There were thick and dense labial adhesions, gentle blunt dissection was done, along the visible midline fusionline (raphe). The interior aspects of the minora and introitus were erythematous but otherwise normal. Genitourinary inspection revealed normal urethral opening, vagina and cervix (Figure 2). Bimanual examination revealed a nulliparous-sized uterus. Foleys catheter with balloon inflated with 20 cc saline kept in vagina for 48 hours.Topical vaginal estrogen cream was applied.Postoperative period was uneventful.



Labial agglutination with introital opening





Foleys catheter wasIntroduced
Separated labia with sims speculum

Figure 1.

She was advised vaginal dilatation and sexual activity for keeping vagina patent. On follow-up evaluation the patient has been able to maintain an open introitus and normal urine flow withcontinued use of vaginal estrogen cream and simultaneous vaginal dilatation. Labial agglutination post traumatic occurring in childhood and presenting in reproductive life is a rare presentation.

Case report 2

The second case was a 42 years unmarried, deaf and dumb female with increasing dysuria for last 20 years. On examination she had average built and well developed secondary sexual characteristics. The labia majora was fused entirely with small opening at the base of labia. The patient underwent examination under anesthesia. The labia was separated very gently, vaginal and urethral opening become visible. On per-speculum examination vagina and cervix was healthy. Daily dressing with estradiol cream was done. The labia was kept separated with gauge piece to prevent fusion.

DISCUSSION

Labial agglutination is mostly seen in the pediatric population. The second case patient was 42 years deaf and dumb, hence the problem may have been ignored. Most of the patients are usually asymptomatic until the fusion occurs over urethral region, which leads urethral symptoms, as seen in second case. Labial adhesions can often be managed with periodic observation, and spontaneous resolution has been reported in as many as 80% within 1 year. Most will resolve once endogenous estrogen production begins. If treatment is necessitated by symptoms or blockage of most of the vaginal opening, topical estrogen cream is indicated (Tebruegge, 2007; Kumetz *et al*., 2006). If medical care does not result in separation of the labia minora, manual or surgical separation may be considered (Hatada, 2003). However, postmenopausal women can experience significant symptoms including urocolpos, inability to void, infections, and interference with sexual activity. Awareness of secondary labial agglutination and its visual presentation is critical in offering management without delay to this patient population. Manual separation without anaesthesia, is not recommended as this can be very uncomfortable for the patient.It is recommended that topical treatment be attempted prior to manual separation, however some postmenopausalwomen have been refractory to conservative management, and surgery may then be required. If manualseparation is required, topical estrogen and/or steroids are then used to ensure separate healing of the labia (Tebruegge *et al*., 2007; Kumetz *et al*., 2006). In long-standing cases of labial agglutination it is also important to perform a complete assessment of the reproductive organs as labial agglutination may limit evaluation or mask common findings that lead to the diagnosis of malignancy such as vaginal bleeding or a palpable mass. Because labial adhesions may be associated with modifiable factors, including vaginal irritation or inflammation, avoiding exposure to possible irritants (eg, strong detergents, bubble baths, and harsh soaps) may be beneficial (Hatada, 2003). Labial agglutination is clinically very important as it may be a cause of anxiety, stress, emotional trauma to patient and her parents. The differential diagnosis includes mullerian agenesis, imperforate hymen, androgenital syndrome & malformations of external genitalia (Leung *et al*., 1996). They are easily treated and tends to recur, hence follow up is required.

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