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HEMATOCOLPOS BY HYMENAL IMPERFORATION: ABOUT A CASE

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ABSTRACT

A 17-year-old girl was referred for pelvic pain with urinary retention unreliable to usual treatments. A pfananstiel-type laparotomy for ovarian cyst was white. The diagnosis of hematocolpos complicated by hematometry with urine retention then suspected. Vulvar inspection confirmed the hymenal imperforation with an overlying tense collection visualized on suprapubic and endorectal pelvic ultrasound. A hymenotomy allowed the evacuation of 400 cc of "chocolate" liquid. Retrospective examination revealed recurrent abdominopelvic pain, which prompted numerous visits to the emergency department. The consequences were simple, allowing the patient to be discharged on the 2nd postoperative day.

KEYWORDS: Adolescent, Hymenal imperforation, Pelvic pain, hymenotomy, urine retention.

INTRODUCTION

Hematocolpos is defined as a collection of menstrual blood in the vagina, by imperforation of the hymen or atresia of the vulvar orifice as part of a malformation of the genitourinary system. Hymenal imperforation is a rare malformation.[1] It is most often diagnosed at puberty before the formation of a hematocolpos by vaginal retention of the first menstruation, associated or not with hematometry or hematosalpinx or even endometriosis.

MATERIALS AND METHODS

Retrospective study on a case of a young girl with a hymenal imperforation complicated by a hematocolpos hospitalized in the gyneco-obstetrical emergency department of the Suissi maternity hospital of the Avicenne University Hospital in Rabat.

This is a 17-year-old girl, admitted for pelvic pain, with a history of a pfannenstiel-type laparotomy for an ovarian cyst who was white a month and a half ago, who has had pelvic pain for about 3 months. gravity associated with primary amenorrhea, constipation and urinary retention which has been probed several times.

The clinical examination objectified (Figure 1).

- well-developed secondary sexual characteristics
- scar from laparotomy (pfannenstiel)
-a bluish bulging imperforate hymen,
- Firm painful mass bulging at the level of the rectovaginal fornix, reaching midway to the umbilicus.

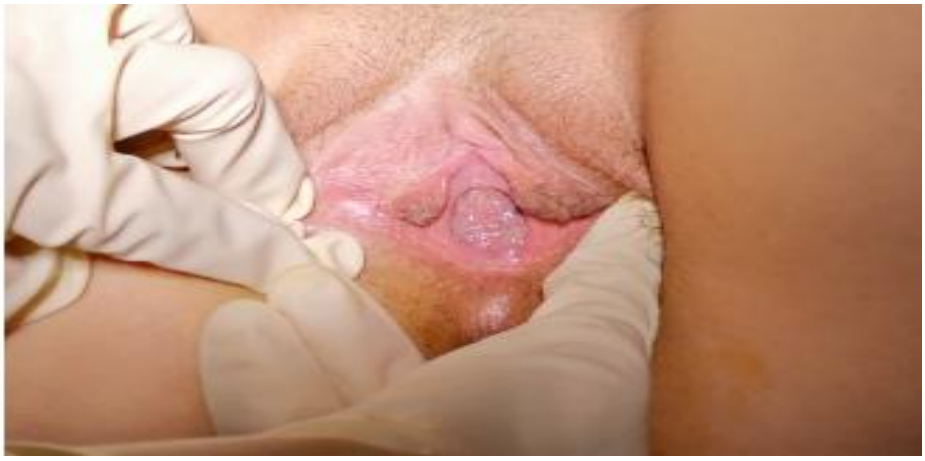

Figure 1: vulvar inspection. Hymeneal imperforation. Note the aspect thick membrane stretched by the overlying vaginal collection and pilolabial development.

Pelvic ultrasound found : (Figure 2)

- a retro-bladder vaginal fluid image with hematic content measuring approximately 12cm long axis extended by hematometry.

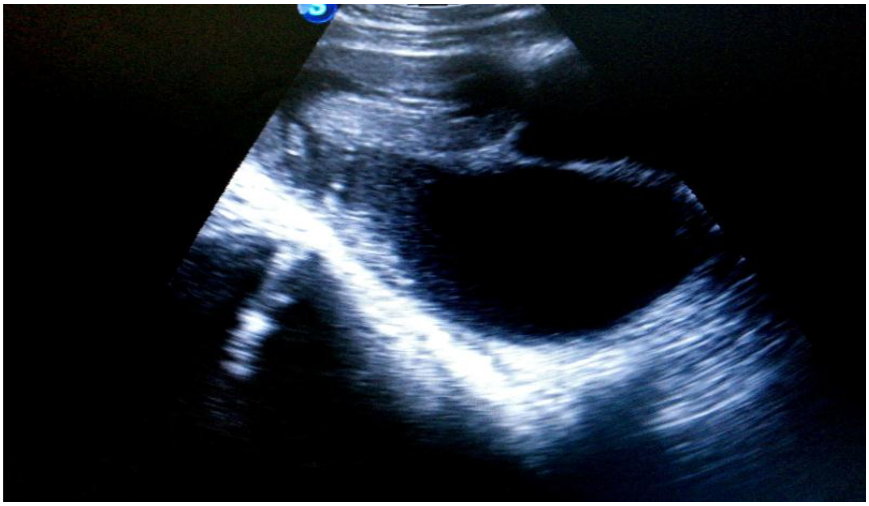

Figure 2: suprapubic ultrasound. Large hematocolpos retrovesical, prolonged by hematometry.

In addition, the patient underwent a partial sagittal hymenotomy (respecting her virginity), which allowed the evacuation of approximately 400 cc of thick, sticky hematic fluid,

The immediate and remote post-operative consequences were unremarkable.

Figure 3: hymenotomy.

DISCUSSION

During intrauterine life, the vaginal bud is channeled towards the end of the 5th month. Its lumen remains separated from that of the urogenital sinus by a thin endodermal membrane,

the partial rupture of which leaves a vestige: the hymen. Congenital hymenal imperforation is rare, affecting 0.1% of female newborns.[2]

The neonatal clinical diagnosis can sometimes be made in the presence of a tense, bluish hymen, corresponding to the intravaginal accumulation of vaginal secretions from the last trimester of pregnancy as well as unexplained functional failure, such as renal failure [3]. The diagnosis can also be suggested antenatal by ultrasound screening (hydrometrocolpos, bilateral hydronephrosis, ascites).[4,5]

But it is sometimes mentioned on the occasion of cyclic pelvic pain which worsens progressively in a girl who has not yet resolved. Often, the diagnosis is only made during an emergency consultation (appendicular syndrome, acute retention of urine, lumbago, chronic constipation)[6,7] Familial forms have been reported.[2, 8] Vulvar examination reveals a thick, bluish hymenal membrane, stretched by the overlying collection, extending from the urethral meatus to the vulvar fork. The rectal examination shows an anterior, renitant mass. The suprapubic ultrasound shows a hematocolpos, a finely echogenic retrovesical image, suggesting a large ovarian endometrioma, sometimes associated with signs of upstream repercussions (hematometry, or even hematosalpinx and peritoneal effusion). Some authors recommend the use of endorectal ultrasound which may pose a problem of acceptability in young patients.[9] The treatment is exclusively surgical. The hymenotomy, conducted radially, 1cm from the urethral meatus is usually not a problem and allows drainage of the overlying collection. A cross incision, or even a hymenal resection with suturing of the lateral edges can prevent their synechiae. Particular attention should be paid to the excretion orifice of the Bartholin glands. It is important to warn the parents as well as the patient of the defloration that the intervention requires. However, some teams suggest performing the procedure using a Foley catheter, whose balloon inflated in the vaginal cavity allows the incision to be controlled in order to preserve the integrity of the hymenal ring. This balloon also allows the hymen to be spread in order to electively achieve hemostasis and prevent re-joining of the hymenal margins leading to secondary stenosis.[10,11] Antibiotic prophylaxis for a few days seems lawful, especially as the collection exceeds the vaginal level. It is based on the combination amoxicillin and clavulanic acid, in the absence of allergy. Finally, a supply of local estrogen can promote healing. An assessment of the repair is usually done 2 or even 3 weeks after the original procedure. The vulvar permeability allowing the appearance and the perpetuation of the rules signs the cure.

CONCLUSION

The diagnosis of hymenal imperforation should be made as early as possible. It should be considered in the event of any acute abdominopelvic pain syndrome in the girl during the pubertal period which has not yet been resolved, especially as the pain is cyclical and the development of secondary sexual characteristics is normal. The clinical examination, whether performed during a routine consultation or in an emergency context, should not omit a careful examination of the external genitalia.[12] The use of ultrasound exploration makes it possible to con fi rm the diagnosis and to identify a possible upstream impact and possible associated urogenital anomalies. Systematic screening at birth and early treatment are the best guarantees of prevention of this pathology at puberty.

Conflicts of interest: No.

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