# Posterior Vault Laceration Following Consensual Sexual Intercourse In A Precoitachial Woman- A Case Report

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## INTRODUCTION

Most injuries to the genital tract are of Obstetric origin. Non-obstetric Coital injuries are common with non-consensual sex (rape), and have been reported.[1, 2] However; there has been a raising trend of coital injury following consensual sexual intercourse in both setting of marriage and illicit sex. [1]

Non-obstetric genital injuries constitute about 1 in 1000 of all patients seen at Gynaecological emergencies. [2, 3] Coitus constitutes about 32% of all non-Obstetrics traumatic lesions of the genital tract. [4] Most of the injuries were minor if it is consensual. It has been estimated that about 10 % of sexual intercourse result in some form of bruising. Even though coital injuries can be life threatening, mortality have not been reported in consensual coital injuries [1,4].

Many risk factors have been proposed for coital injuries. This include male to female disproportion commonly seen in young women having their sex debut. Other factors include lack of adequate fore play, position during intercourse, long period of sexual abstinence, and use of aphrodisiacs,[2,4,5] young age, illicit coitus, non-consensual sex. [6]

Coital injuries commonly presents with per vaginal bleeding and perineal pain. [1] Lacerations are the commonest injuries at presentation even though women who have minor bruises do not usually come to the hospital. The lacerations commonly occur at the posterior fornix as in this case.

Most coital injuries are treated via simple repair with local infiltration with anaesthetic agents.[5] Severe cases may however require regional or even general anaesthesia to allow for examination under anaesthesia (EUA) to adequately asses the wound.

Complications include haemorrhage which can be life threatening, wound infection if neglected (even peritonitis). The psychological effects can be enormous especially for young women who are having intercourse for the first time. With counselling, however most will adjust appropriately.[6]

## CASE REPORT

The patient is 18 year old para 0 plus 0, who presented at the Gynaecological emergency of our Hospital on 10th December, 2014 with 3 hours history of per vaginal bleeding following sexual intercourse with her Husband.

The bleeding was said to be significant but she cannot quantify it. She had however used about 3 fully soaked pads before arriving at the Hospital. There was no history of dizziness, blurring of vision or body weakness. There was however associated lower abdominal and vulvar pains.

The Patient got married 2 days prior to presentation and this was her first sexual experience. The foreplay lasted less than 30 minutes. The husband admits to taking aphrodisiacs for the sexual encounter (Popularly called 'buran tashi' in local parlance).

She was the second wife of her husband who was a 35 year old Business man.

On examination, she was a young woman who was apprehensive. She was not pale, afebrile (Temperature 37.2 $0^{c}$), not jaundiced. Her wrapper was obviously stained with fresh blood.

Her respiratory rate was 18cpm, and her breath sounds vesicular.

Her pulse rate was 82 per minute (pm) and blood pressure was 110/70mmHg; her heart sounds were normal.

The abdomen was full and moves with respiration. There was mild supra-pubic tenderness. The Spleen and Liver were not palpably enlarged and the Kidneys were not ballotable. There were no palpable intra-abdominal masses. The bowel sounds were normal.

The vulva and vagina were normal. There was however some bruising at the labia minora at 7 o clock position involving the hymenal ring. Bright red blood was seen oozing out of the intriotus. The uterus was normal size and ante-verted.

The cervix looked healthy and the os was closed. The vaginal wall was capacious with soft walls. There was a deep laceration at the posterior fornix extending laterally in a U-shape manner. It measured about 5cm in length and actively bleeding. The peritoneum was not breached.

The vagina was packed with gauze to minimize bleeding. The

problem was explained to the patient and the management outlined. Sample for investigations were taken. [PCV : 37%, Blood group: O, RH D positive, Urinalysis: Normal]

Informed consent was taken. One unit of blood was grouped and crosshatched. Intravenous access was secured and patient was given 1 litre of normal saline to run 8 hourly.

Patient was given light sedation / analgesics ( IV Pentazocine 60mg start and IV Promethazine 25mg start) Local infiltration with 10mls 1% Lidocaine was given around the site of injury.

The findings at pelvic/speculum examinations were confirmed.

The posterior lip of the cervix was held by volsellum and the laceration clearly visualized. The wound laceration was repaired with Vicryl 2.0 using single layer interrupted stitches. The bleeding stopped immediately after the application of the stitches.

The patient was admitted into the Gynaecological ward. Her vital signs remained stable. She was given oral Amoxicillin-clavulanate 625mg 12 hourly, oral metronidazole 400mg 8 hourly and oral Diclofenac 50mg 8 hourly all for 5 days.

Her PCV the next day was 32 %. She had no complaints and her vital signs were stable.

The couple were counselled on human sexuality and their fears allayed. She was then discharged to see clinic in 2 weeks.

**DISCUSSION**

The patient was, 18 year old woman who presented at our emergency unit with consensual coital injury. Most non-obstetric coital injuries found among this age are associated with short time of fore play and use of aphrodisiacs.

She presented with per vaginal bleeding and lower abdominal pain. The bleeding would have proven serious if not for the timely presentation, seeing a drop in the Pack cell volume from 37% to 32%. The injury was a posterior vault laceration with involvement of the peritoneum. A few posterior vault tears may involve the peritoneum with resultant peritonitis.

Even consensual sex maybe associated with serious injury. Partners need to be educated on the raising trend of injuries (both physical and emotional) during consensual sex.

This will help to improve the sexual and reproductive health and rights of women.

**REFERENCES**


1. Tchounzou R, Chichom-Mefire A. Retrospective analysis of clinical features, treatment and outcome of coital injuries of the female genital tract consecutive to consensual sexual intercourse in Lembe Regional Hospital. Sex Med 2015 Dec; 3(4):258-260.
2. Abasiattai AM, Etuk SJ, Bassey EA, Asuque EE. Vaginal injuries during coitus in Calabar: a 10-year review. Niger Postgrad Med J 2005 Jun; 12(2):140-144.
3. Omo-Aghoja LO, Ovbagbedia O, Feyi-Waboso P, Okonofua FE. Coitally related traumatic injury of the female genital tract in a Nigerian urban setting: a 5year review. Niger Postgrad Med J 2009 Mar; 16(1):59-63.
4. Jana N, Santra D, Das D, Das AK, Dasgupta S. Non-Obstetrics lower genital injuries in rural India. Int J GynaecolObstet 2008 Oct; 103(1):26-29.
5. Lincoln C, Perera R, Jacobs I, Ward A. Macroscopically detected female genital tract injury after consensual and non-consensual vaginal penetration: A prospective comparative study. J Forensic Leg Med 2013 Oct; 20:884-901.
6. Cisse CT, Dionne P, Cathy A, Mendes V, Diadhiou F, Ndiaye PD. Vaginal injuries during coitus. Dakar Med 1998; 43:135-138.