

## COITAL LACERATION IN SHOCK: A CASE REPORT.

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## Abstract

**Background:** Coital lacerations vary from minor self-limiting vaginal injury with minimal 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.

**Case presentation:** A 19-year-old senior secondary school student who presented to the gynaecological emergency unit with coital laceration in shock. She was resuscitated, and had repair in theatre.

**Conclusion:** Coital laceration is usually mild. It could be life-threatening in severe cases. Prompt diagnosis and management of severe cases will reduce the morbidity and mortality associated with it.

**Keywords:** Coital laceration, shock, life-threatening, morbidity, mortality.

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## INTRODUCTION

Coital lacerations are under-reported in our environment<sup>1,2</sup>. They vary from minor self-limiting vaginal injury with minimal 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<sup>3,4,5</sup>.

## CASE PRESENTATION

She was a 19-year-old Para 0<sup>+0</sup> senior secondary 3 student who presented to the gynaecological emergency unit of the Federal Medical Centre, Yenagoa with a two-hour history of sudden onset vaginal bleeding following sexual intercourse with her boyfriend. Bleeding was active and bright red. She initially used eight sanitary pads in attempt to

contain the bleeding. She was sexually active but had three-month period of abstinence from sexual intercourse before the present one. There was no adequate emotional and physical foreplay prior to sexual act. The position used was the dorsal position. There was no loss of consciousness, drug use before intercourse, rough sexual act, or use of sex toys during the act. When bleeding continued with associated progressive weakness and dizziness, she presented to the Federal Medical Centre, Yenagoa for management.

Examination revealed a lethargic young lady. She was pale, anicteric, afebrile with an axillary temperature of 36.5 °C. Her pulse was not palpable. Her blood pressure was 80/40 mmHg. Her abdomen was full and moved with respiration.

There was no area of tenderness. There was active bleeding per vaginam, with massive blood clots in the vagina. A gentle sterile speculum examination revealed a 5 cm S-shaped vertical laceration at the posterior fornix of the vagina, bleeding actively. A gentle digital examination revealed a grossly normal cervix that was firm, with its os closed. The uterus was normal in size and anteverted. The Pouch of Douglas was empty and the adnexae were normal.

A diagnosis of coital laceration in shock was made, and there was call for help. As she was being resuscitated with 1 litre of intravenous fluid normal saline fast, an assistant explained the findings and diagnosis to her, her boyfriend and her mother. She was counselled for immediate repair in theatre. The procedure was explained to them and an informed consent obtained. Theatre was booked for the procedure. The anaesthetist was informed. Blood and urine samples were taken for laboratory investigations. Her packed cell volume was 24% and her blood group was O Rhesus 'D' Negative. Two units of blood were grouped and cross matched as she was quickly wheeled to the theatre.

Intra-operative findings were a 5 cm S-shaped laceration from the posterior cervicovaginal junction along the posterior fornix of the vagina to the posterior wall of the vagina; bleeding actively. There were grossly normal cervix and normal uterus and adnexae.

The S-shaped laceration was identified, and repaired in continuous non-locking pattern with chromic catgut 1. She received 2 units of blood intra operation. Total estimated blood loss was 2 litres. Her immediate postoperative condition was satisfactory. She received 2 more units of blood post operation. Her post transfusion packed cell volume was 31% and was discharged home on the third post-operative day with two weeks' appointment to the gynaecological clinic.

At the follow-up visit, she had no complaints and her general condition was satisfactory. The vaginal wound had healed satisfactorily. She had sex

education and counselling to help prevent recurrence, and was discharged to the family planning clinic for contraceptive.

## DISCUSSION

The incidence of post coital laceration among gynaecological patients is 0.7% in Abraka and Calabar<sup>6, 7</sup>. In Maiduguri, a lower incidence of 0.34% was reported<sup>1</sup>. The low incidence may be as a result of the shame and secrecy attached to coital vaginal injuries which makes most cases to linger in silence and only a few severe cases and those due to rape report to the hospital for medical help<sup>1, 6, 8</sup>. This patient and her boyfriend initially kept her condition secret but presented to the hospital for management when bleeding continued with worsening clinical condition. In Senegal and United States of America, an average of 30 and 32 cases are seen every year respectively<sup>9</sup>.

Rape is the commonest aetiological factor for coital vaginal injuries, followed by nulliparity<sup>7</sup>. The predisposing factors to coital injuries include first sexual intercourse, prolonged abstinence, positions such as dorsal position, rough coitus, peno-vaginal disproportion, use of aphrodisiacs as vaginal lubricant and inadequate emotional and physical preparation of women for sexual intercourse<sup>2, 3, 7</sup>. Others include pregnancy, puerperium, post-menopausal vaginal atrophy, and congenital and acquired shortness of the vagina<sup>1</sup>. This patient had a 3-month period of abstinence from sex. There was no adequate emotional and physical foreplay prior to sexual act and the position used was the dorsal position.

Complications such as haemorrhage, injury to abdomino-pelvic organs, sepsis, vaginal stenosis, recto-vaginal fistula, vesico-vaginal fistula and death<sup>10</sup>. Peritonitis from rupture of the posterior fornix of the vagina has also been reported, but it is very rare<sup>11, 12</sup>. In this case, she had severe life-threatening haemorrhage which lead to shock.

An important differential diagnosis of coital vaginal injury is acute abdomen with or without vaginal bleeding<sup>3</sup>.

Management include resuscitation with intravenous fluid, transfusion in severe blood loss and surgical repair of the laceration. Sex education and counselling is essential in preventing this condition from happening or recurring, as this was incorporated into her management<sup>10</sup>.

## CONCLUSION

Coital injury occurs occasionally and is usually mild. It could be life threatening in severe cases like that of this case. Most cases result from rough and hurried sexual intercourse. Prompt diagnosis and management of severe cases will reduce the morbidity and mortality associated with coital injuries. Appropriate counselling and sex education will help prevent this condition.

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