ABSTRACT

Labial adhesion is characterized by partial or complete fusion of labia minora or labia majora. It is rare in menopausal women. It is usually a triad of estrogen deficiency, inflammatory skin disorders and lack of sexual activity. Patients are mostly asymptomatic until labial fusion is complete. The most common symptoms are urinary retention and urinary tract infections and incontinence. It is usually diagnosed on examination of external genitalia. The treatment is not well established, owing to low prevalence in menopausal population. The most common methods of treatment are manual separation and surgical excision. Postoperative application of local estrogen cream is vital to prevent recurrence.

Keywords: Incontinence, Labial Adhesion, Menopause, Voiding.

1. Introduction

Labial adhesions are defined as complete or partial adherence of labia minora or majora in the midline through dense or flimsy adhesions. It may be primary or secondary. Primary labial adhesions usually occur in young girls before puberty. Secondary labial adhesions occur usually in menopausal women due to estrogen deficiency. Patients are usually asymptomatic but may present with various voiding or valvul symptoms. Labial adhesions are a rare cause of voiding difficulty. The incidence of labial adhesions is about 0.6–1.4% in children, but the incidence in elderly is unknown, and only a few case reports are documented in postmenopausal women [1]. The condition is more common in prepubertal girls and is very rare in menopausal women. The menopausal women may be embarrassed to mention the problem on seeing a physician. Labial adhesion is also known as synechiae of vulva, labial fusion, agglutination of vulva.

We present the case of menopausal women, who present with spraying of urine on micturition. The woman was treated with surgical division of adhesion followed by local application of estrogen. The patient had complete resolution of symptoms, with no recurrence till one year of follow up.

2. Case Presentation

A 62 years old menopausal woman with no underlying disease presented to our outpatient department as a case of voiding difficulty. On voiding the urine was spraying from last 6 months. There was no history suggestive of urinary tract infection and retention. Patient has not had any sexual relationship for the last 25 years. She had two children, both born by caesarean section and her last childbirth was 25 years back.

Labial fusion is diagnosed on examination. Physical examination revealed complete fusion of labia minora both anterior and posterior with a pinhole opening at anterior 1/3 of introitus (Fig. 1). There was no rash, edema or hardening of skin. Clitoris and external urethral meatus were not visible. Pubic hair was sparse and consistent with her menopausal status. Urology review was done and urinary obstruction was ruled out. Kidney function was normal. The manual separation was unsuccessful because of pain and surgical excision was planned. The patient was placed in lithotomy position and operation was done under general anesthesia. The dissection was performed along adhesion line, exposing clitoris, external urethral orifice and vagina. The labial tissue was excised and sutured by 2-0 vicryl (Fig. 2). The 14 F urinary catheter was passed confirming the urethral patency. The patient recovered well in the postoperative period, was discharged home on same day. Strict perineal hygiene with local use of estrogen cream was vital to prevent recurrence.
3. Discussion

The exact cause of labial fusion remains unknown but it occurs mostly due to estrogen deficiency both in prepubertal girls and menopausal women, and is commonly associated with lack of sexual activity and inflammatory skin disorder [2]. The most common associations include inflammatory skin disorders like lichen sclerosis, lichen planus, trauma, radiation, atrophic vaginitis [3]. The labial fusion may be partial or complete. Fusion usually starts at the posterior fourchette and progresses toward the clitoris. The presentation varies from being asymptomatic to vulvar symptoms like pruritus, discharge, dyspareunia and voiding difficulties like urinary tract infections, urinary incontinence (pseudo incontinence), urinary retention [4]. Labial adhesions occur mostly in prepubertal girls. The expectant management is appropriate for this asymptomatic population, due to the fact that estrogen production is going to increase with puberty. Estrogen deficiency is common in menopausal women; however, they rarely have labial adhesions. Local application of estrogen cream is treatment of choice in these patients, due to natural decline in production of estrogen by ovaries. Daily application of topical estrogen has success rate of 50–88% within two-eight weeks, with a recurrence rate of 35% [5]. There are no guidelines on length of medical management. Topical application of steroid ointment for inflammatory disorders may be given simultaneously [6]. Treatment modalities are not well defined. The most common surgical approach is manual separation (lateral traction). The amount of pressure to be applied is not defined.

Other surgical approaches include division of adhesions, reconstruction by skin flap. Reconstruction by skin flap is reserved for patients with thick adhesions and in case of recurrent labial adhesions [7]. Even after surgical separation, there is risk of readhesion. Thus, the postoperative local use of estrogen cream helps to minimize the chances of readhesion [8].

4. Conclusion

Labial adhesion in menopausal women is usually triad of estrogen deficiency, inflammatory skin disorders, lack of sexual activity. Few cases have been documented in literature. The pelvic examination should be priority especially when a menopausal woman presents with vulvar symptoms or voiding difficulty. The condition should be properly managed. Surgical separation followed by estrogen application is usually the treatment of choice.

Conflict of Interest

The author declares no conflict of interest.

References