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Consensual Coital Lacerations: A Case Series

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Abstract

Consensual coital lacerations are commonly encountered in clinical practice. Though not as common as lacerations sustained during childbirth, they account for significant morbidity among sexually active women. Consensual sexual intercourse should ordinarily not cause pain as opposed to rape. It commonly results from inadequate foreplay prior to penetration leading to non-lubrication of the vagina. Severe coital laceration may lead to life threatening blood loss. The authors report their experience with treating patients with coital laceration. The mechanism of injury and treatment modality were also highlighted. Three cases are presented. The first patient bled profusely from the laceration and went into shock due to severity of bleeding. The second case presentation was similar to the first only that she was haemodynamically stable at presentation without any sign of shock. The last case was a newlywed who was having sexual intercourse for the very first time. All three patients were not adequately lubricated prior to penetration due to inadequate foreplay. All three cases were consensual and were either with the lover as in the first two cases or the spouse as in the third case. None of them was circumcised or had had any form of genital mutilation. The case series bring to fore the common mechanism of consensual coital laceration, the need for clinicians to have high index of suspicion when reviewing susceptible patients as well as proper and prompt management of the condition which may require surgical repair as was in all the cases highlighted.

Keywords: Consensual; Coital; Laceration; Penetration

Introduction

Coital lacerations are common in our environment, though under-reported [1-3]. 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 [3-5].

Case Series

Presented are three patients with consensual coital vaginal lacerations who were managed by the authors. They all had severe vaginal injury associated with profuse bleeding. One of the patients came with hypovolaemic shock. None of them was circumcised or had any form of genital mutilation. Their presentation and management is discussed below after obtaining approval from the ethics committee.

Case 1

A 25 year old P_0^{+0} single lady who had a deep transverse laceration about 4cm on the posterior fornix of the vagina. She also had multiple superficial vaginal lacerations with a 1.5 cm laceration at the introitus on the inner lip of the right labia minora and a 1cm laceration on the left lateral mid vaginal wall. She presented two hours after onset of bleeding and had hypovolaemic shock on initial assessment. She sustained the injuries on having sex with her fiancé who has been away for three months. There was no adequate foreplay prior to penetration.

Case 2

A 25 year old P_0^{+1} single lady who had a deep longitudinal laceration on the posterior fornix of the vagina extending to the perineum. She presented to the hospital twelve hours after onset of vaginal bleeding. She has not had sex for three years and was having sex with her new boyfriend for the first time. Foreplay was not adequate and she was not properly lubricated.

Case 3

A 27 year old P_0^{+0} newly wed who had a deep laceration about 2 cm on the left posterior-lateral wall of the vaginal introitus. She presented three days after onset of bleeding. She was having sex for the very first time and thought the bleeding was from the hymen and only presented when it persisted. There was no adequate foreplay as it was also the first time the husband was having sex.

Treatment

The first patient required aggressive fluid resuscitation to reverse the shock. All the patients were promptly taken to the theatre where they had examination under general anaesthesia. The lacerations were repaired primarily with continuous interlocking chromic catgut 0 sutures and haemostasis secured. All the patients had digital rectal examination to ensure that the rectal mucosa was not involved in the laceration as well as ensure that the rectum was suture free. The packed cell volume for all the patients both pre and post operatively was adequate. None of the patients was transfused though they were all placed on haematinics. The bladder and urethra were also examined to rule out urinary tract injury. They were all discharged within forty eight hours and there were no perioperative complications.

Discussion

Consensual coital vaginal injury is a usual occurrence, though under-reported in our environment, particularly during coitarche [1-3]. It can vary from minor self-limiting minimal vaginal 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 [3-5]. Peritonitis from rupture of the posterior fornix of the vagina has also been reported, though extremely rare [6,7]. The first and second patients had major lacerations in the posterior fornix but were however without perforations. Studies done in Abraka and Calabar reported that 0.7% of gynaecological patients seen presented with vaginal injuries [8,9]. A lower incidence of 0.34% was reported in Maiduguri [1]. The low incidence may be related to the shame and secrecy attached to the condition 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 [1,8,10]. An average of 30 cases and 32 cases are seen per year in Senegal and United States respectively [11].

Abasiatta et al. reported in his 10 year study that rape was the commonest aetiological factor for coital vaginal injury and it was more common in nulliparous patients [9]. The common predisposing factors to coital injuries include rough coitus, first sexual intercourse, harmful positions such as dorsal decubitus position, peno-vaginal disproportion, and use of aphrodisiacs as vaginal lubricant and inadequate emotional and physical preparation of women for sexual intercourse [2,3,9]. Others include post-menopausal vaginal atrophy, pregnancy, puerperium and congenital and acquired shortness of the vagina [1]. All the patients above were not emotionally ready for sex and did not have adequate foreplay prior to penetration. The third patient had the laceration on her coitarche and this could make her have a negative impression about sex. This is true for most women in our environment where sex is hardly negotiated and rape by male partners in a consensual relationship is not considered rape and therefore underreported [1].

Prompt and proper management of this condition is important to prevent complications such as haemorrhage, sepsis, vaginal stenosis, injury to abdomino-pelvic organs, recto-vaginal fistula, vesico-vaginal fistula and death from occurring. A rectal examination must be performed in all cases of coital injuries on the posterior vaginal wall to rule out rectal involvement leading to rectovaginal fistula. A differential diagnosis of severe upper vaginal injury should be kept in mind in females who present with an acute abdomen with or without vaginal bleeding following coitus [3]. 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 and should be incorporated in management. Patient and her partner were counselled on the importance of negotiating sex and having adequate foreplay as well as correct use of contraceptive.

In conclusion, Coital injury, though commonly encountered and mild, could be life threatening. Most cases result from rough and hurried coitus leading to functional peno-vaginal disproportion. It is thus preventable in most cases. The Family Physician should be able to promptly and properly diagnose and manage coital injuries when they present. Efforts at prevention including appropriate counselling and sex education should form part of our routine practice.

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