Section of Obstetrics and Gynæcology

President—MILES PHILLIPS, M.D.

[*March 18.—continued*].

Congenital Absence of the Vagina, treated by Means of an Indwelling Skin-Graft.—J. BRIGHT BANISTER, F.R.C.S., and A. H. MCINDOE, M.S., F.R.C.S., F.A.C.S.

The patient now shown underwent an operation six months ago for the formation of an artificial vagina.

She was referred to us by Mr. Chapman of Grimsby who, on examination, had found no trace of a vagina and advised her to come for treatment as the question of nubility had arisen.

Examination, under an anæsthetic, revealed complete absence of the vagina, but a fairly well-formed vulva was present. On rectal examination a small knob was felt in the position of the uterus, but there was no trace of ovaries. The secondary characteristics were entirely feminine. Operation was decided upon and carried out on September 27, 1937, as follows :—

A hollow vulcanite mould, completely closed at both ends, had been previously prepared by our dental colleague Mr. Alexander Kay, roughly the size and shape of a distended virgin vagina (fig. 1). This was intended to carry the skin-graft and to

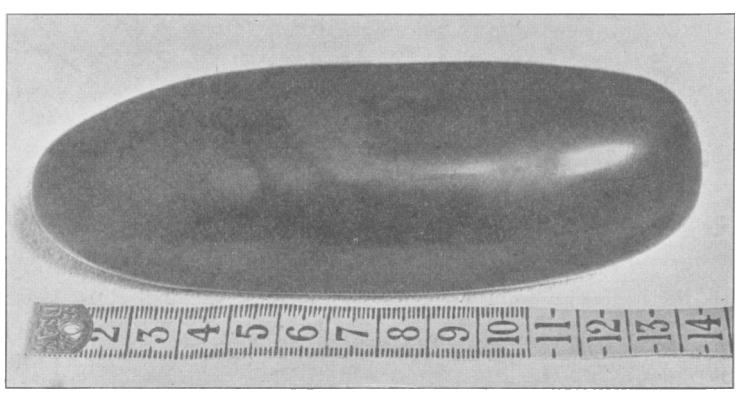

FIG. 1.—Hollow vulcanite mould used to carry the skin graft.

maintain the patency of the vagina during the entire contractile phase. A thin razor-graft was first cut from the inner surface of the left thigh where hair was least apparent. This graft was roughly 9½ in. long by 2½ in. wide. The patient was then placed in the lithotomy position and thorough sterilization of the vulva was carried out, care being taken to see that the anus was excluded from the operative field. An incision was made from a point half an inch posterior to the urethral meatus and carried vertically backwards to a point three-quarters of an inch in front of the anus. The plane of cleavage between the rectum and the bladder was then entered and by blunt dissection a cavity was established which was gradually enlarged upwards until it would just accommodate, under moderate tension, the vulcanite mould previously prepared. Bleeding proved to be almost negligible, and a dry field was easily obtained. The mould was then painted with mastisol and covered with the skin graft, raw surface outwards, in such a way that the combination of adhesive and the lie of the graft prevented the skin rucking-off during insertion. The skin-covered mould was finally inserted into the cavity and the labia minora were freshened and

sutured across its lower end leaving a small hole anteriorly just behind the meatus for drainage.

For seventy-two hours after operation the patient required a fair amount of sedative. There was a profuse discharge for the first ten days, after which it gradually diminished in amount, and in four weeks had almost disappeared. The perineal wound healed rapidly, all stitches being removed on the tenth day. The bowels were not opened until the eighth day. The temperature rose to 101° occasionally during the first seven days, but became normal on the fourteenth day. The patient was up on the nineteenth day. After the fourteenth day she noticed that there was some movement of the obturator when she turned in bed. She was discharged on the

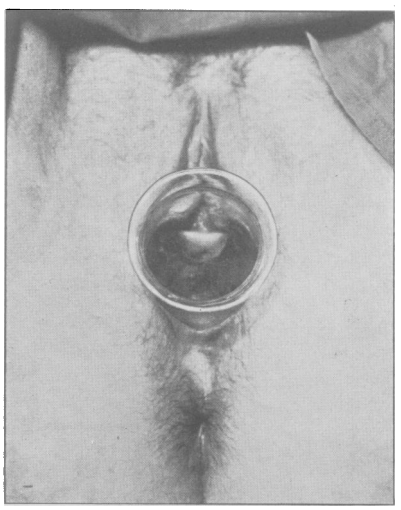

FIG. 2.—Skin-grafted vagina containing full-sized glass vaginal rest five months after operation.

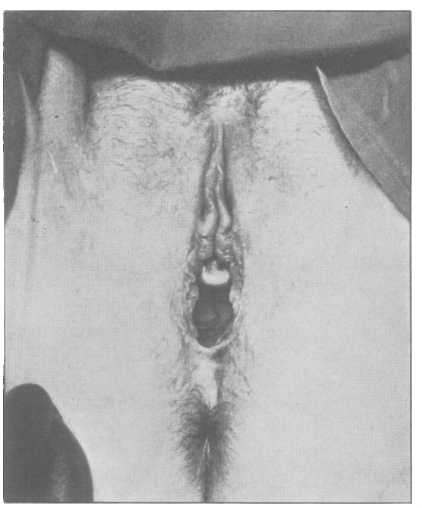

FIG. 3—Appearance of the new vagina after removal of the rest.

twenty-sixth day to her home in Yorkshire where Dr. Clarke, of Rotherham, has been in charge of the case. On December 12, 1937, he reported her condition as follows :—

"Getting about is difficult owing to an aching pain which comes on after exertion, but she can sit with comfort on an air ring for two or three hours at a time. She has no difficulty with bowels or bladder. She feels that the obturator is moving both backwards and forwards and she thinks there is some rotation. There is a thin yellow discharge which is odourless and not irritating."

On January 13, 1938, the patient returned to the Chelsea Hospital and the vaginal mould was removed. The skin-graft had taken perfectly everywhere except for a small area at the lower end where it lay in contact with the labia minora. The walls were smooth, white, and soft, and approximated very closely to normal vaginal mucosa.

A glass vaginal rest of the largest size was easily inserted into the cavity and this was worn every night for a further six weeks (fig. 2).

For a short time half-strength eusol douches were given daily to disinfect the lower segment where a slight irritation was evident. Now, at the end of five months, the new vagina has completely healed and shows no tendency to contraction either in length or breadth. The introitus admits two fingers with ease and the dimensions of the new vagina are 5 in. × 2 in. (fig. 3).

[With Mr. C. D. Read, Mr. McIndoe showed another case in which this operation had been performed only fourteen days previously. Members of the Section were thus able to see the intermediate condition as well as the final one.]