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BRIEF COMMUNICATION

Labial fusion causing pseudoincontinence in an elderly woman

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KEYWORDS

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Adhesions of the labia are rare in the adult population with only a few cases described in the English literature. The etiology of labial adhesions probably relates to vaginal inflammation or irritation. Once the superficial epithelium of the labia is denuded subsequent healing leads to fibrous adhesions between the labia. Etiological factors for labial fusion in adult women are local inflammation, senile vaginitis, hypoestrogenism, lack of sexual activity, local trauma, vaginal laceration following childbirth, female genital cutting (infibulation) and recurrent urinary tract infections [1–3]. There could be skin pathology in the form of genital herpes or lichen sclerosis [2].

A 55-year-old postmenopausal woman presented with a history of incontinence, straining at micturition, and a vaginal itching sensation. The incontinence was continuous with intermittent normal voiding although the urinary stream was weak. Routine urine analysis revealed 8–10 white blood cells/high power fields, and the urine culture was sterile. General physical examination was within normal limits. Pelvic examination demonstrated extreme labial fusion with only a pinhole opening (Fig. 1). There was also perivulvar skin excoriation and the labia

were exquisitely tender to palpation. Perirectal examination revealed no evidence of anterior bulging suggestive of urocolpos. Conservative management in the form of local estrogen cream application was instituted without improvement. The woman underwent labial separation under spinal anesthesia. There were also vaginal synechiae and urethral stenosis which were lysed and dilated with Hegar's dilators (Fig. 2). Post-operatively the patient was instructed to apply estrogen cream locally. At 3 months of follow-up, the local mucosa was healthy with no recurrence.

Labial fusion may be incidentally detected or it may have varied presentations such as vulvodynia, vaginal pruritus, and voiding difficulty [4]. This case presented with pseudoincontinence caused

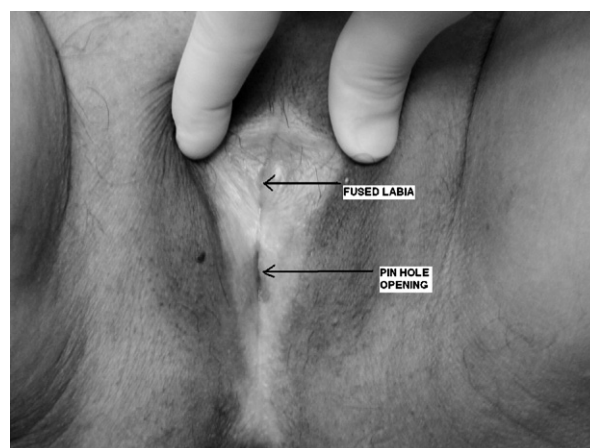


Figure 1 Labial fusion with only a small opening.

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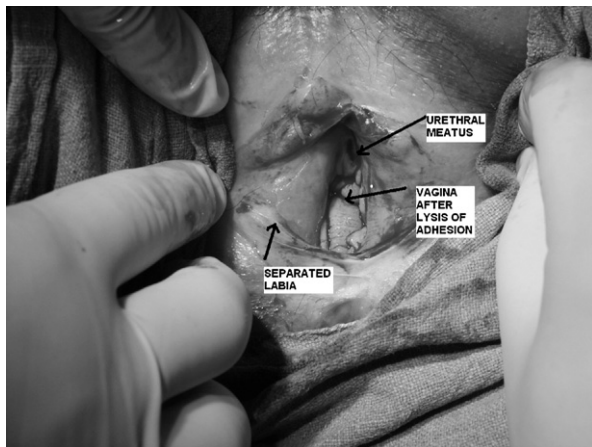


Figure 2 Final appearance after labial separation, lysis of vaginal synechiae, and urethral dilation.

51 by collection of urine in the space behind the fused labia. The
 52 stenotic urethra could have added to the voiding problems. Arango
 53 Toro et al. [5] presented a similar case of labial fusion resulting in
 54 pseudoincontinence.

55 Treatment is most often conservative in the form of estrogen
 56 cream for hypoestrogenism and atrophic mucosa. Labial separation
 57 should be employed when this treatment fails; but as the
 58 labia are often tender the separation may need to be done under
 59 anesthesia. In addition, the presence of vaginal synechiae or
 85

urethral stenosis can make regional or general anesthesia 60
 desirable. Postoperatively estrogen or steroid cream should 61
 help to prevent recurrence of the problem. Steroids are 62
 certainly of benefit when lichen sclerosus is present. In the 63
 recurrent cases repeat surgery may be needed. There are 64
 reports of amniotic membrane coverage and advancement flap 65
 surgery used for the refractory cases. Labial fusion is a rare 66
 condition in adults, most often caused by hypoestrogenism. 67
 While conservative topical estrogen therapy may suffice, labial 68
 fusion may persist and require surgical intervention. 69

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