

Vaginal foreign body causing recurrent discharge and vaginal stenosis - a case report

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ABSTRACT

Chronic vaginal discharge in children and adolescents is a common gynaecological complaint which is often resistant to antibiotic treatment. We present a 14 years old, premenarcheal girl who presented to us with the complaints of recurrent, foul smelling purulent occasionally blood stained vaginal discharge for eight years, where a foreign body in the upper vagina was found after releasing a dense adhesion of the lower vagina which was unable to detect by pelvic ultrasound.

Keywords: Chronic vaginal discharge, premenarcheal, foul smelling, foreign body, dense adhesion.

The etiology of chronic vaginal discharge in a young adolescent are numerous, they may be infection, sexual abuse, congenital malformation, vulvar skin disease, vaginal neoplasm and a foreign body. So a foreign body in the vagina should always be kept in mind when a young girl presents with chronic vaginal discharge. Such foreign bodies are introduced in the vagina either by the curiosity of the child or for the sexual gratification. There are three aspects of diagnosis in this condition. The first is inspection of vulva and vagina second is diagnostic procedures like pelvic USG and MRI, thirdly Examination under anaesthesia. How ever the negative findings in USG and MRI should not always rule out the foreign body.

CASE REPORT

A 14 years old adolescent, from remote Lamjung District was brought to the gynecological OPD by her aunt with the complaints of vaginal discharge for last 8 years and pain lower abdomen for the same duration.

She was apparently well 8 years back when she developed P/V discharge which was insidious in onset and associated with pain lower abdomen. The discharge was continuous, not profuse, purulent occasionally blood stained, foul smelling not associated with itching but associated with vulval irritation. There was no h/o trauma, foreign body insertion or sexual abuse. No h/o fever and increased thirst. Bowel and bladder habits were unchanged. Menarche was not attended. In the past treatment history she was frequently treated in the village local pharmacy shop with antibiotics and vaginal tablets which improved the symptoms temporarily. She belongs to middle class family with three siblings.

O/E GC was fair, Vitals were normal, thin built, thelarche +, No axillary hair was developed. On local examination no pubic hair was present, vulva reddened, serosanguinous discharge seen in the vulva, hymen was torn and vaginal examination revealed a blind ending vagina with a small puckered area in the middle.

A vaginal swab was sent for microbial culture and sensitivity and antibiotic started. Pelvic USG revealed normal pelvic USG (no growth and foreign body detected). Blood counts were normal.

Patient was admitted in the gynaecological ward for EUA. Operative findings were: Serosanguinous discharge seen in the vulva with red, inflamed vulva. A dense vaginal adhesion about 3 cm distal to the hymenal rim was noted. Vaginal swab was taken and sent for microbial culture and sensitivity. Small granulation tissue seen at the adhesion site which was removed and sent for HPE. Adhesion was carefully separated with the help of sound followed by artery forcps. After separating the adhesion upper vagina was explored with the help of little finger and a hard irregular FB of about 2x1.5 cm fruit seed was felt which was removed with artery forceps. Blood loss was minimal. Vaginal wall was painted with Ooestradiol cream (Evalon cream). Rectal mucosa was intact (fig.1).

Post operatively treated with septran, metron and local evalon cream. On third post operative day she was discharged with the same treatment. She came for three more consecutive weeks for follow up and the vagina was painted with Evalon cream and went home there after. Vagianl swab showed no growth, histopathological examination of the tissue revealed inflammatory granulation tissue and no evidence of malignancy.

DISCUSSION

The prevalence of vaginal foreign bodies in outpatient girls under 13 years of age with gynaecologic disorders was found to be 4.0%.¹

The long standing foreign body (fruit seed) in the vagina has caused this chronic vaginal discharge, dense adhesion and formation of granulation tissue in this young adolescent. Similar case has been reported by Deborah *et al*² in a 13 years old girl who presented with chronic vaginal discharge after each menses and found to have foreign body in the upper vagina and dense adhesion of it.

Similarly Caldwell³ reported a 23 years old girl with almost 20 years of vaginal discharge found to have foreign body in the vagina with dense adhesion and scarring with almost obliteration of it. McAllister also found a foreign body (flash light bulb) and vaginal stenosis in an 11 years old girl who complained of intermittent foul-smelling vaginal discharge for 9 years.⁴ Recurrent vaginal discharge with scarring and adhesion of vagina is believed to be due to the chronic inflammatory reaction caused by different type of foreign body present in the vagina for years. There has been different kind of foreign body found in the vagina in cases of chronic vaginal discharge among which the most common was tissue paper (40.0%).⁵

Caspi *et al*⁶ advocate USG as the first step in the evaluation of suspected vaginal foreign bodies in young girls where varying echogenicity and acoustic shadow can be observed occasionally but always an indentation of the posterior bladder wall is clearly observed. In the mean time Kihara *et al*⁷ claim that MRI is the best diagnostic method for evaluating vaginal foreign bodies in young girls. We believe that examination under anaesthesia should be the first line of investigation and treatment in cases of resistant chronic vaginal discharge though some authors advocate investigative procedures such as pelvic and perineal ultrasonography, MRI and plain X-ray which are always not helpful in detecting foreign bodies in the vagina. In every case whether the investigative procedure is positive or negative an EUA is done either to remove the foreign body in positive cases or EUA is done in negative cases. The clinician should always think of foreign bodies in the vagina in cases of chronic, antibiotic resistant vaginal discharge.

REFERENCES

1. Paradise JE, Willis ED. Probability of vaginal foreign body in girls with genital complaints. *Amer J Dis Child* 1985; 139: 472-6.
2. Deborah A, Simon BS, Scott B, John B, Keith H. Recurrent purulent vaginal discharge with long standing presence of a foreign body and vaginal stenosis. *Paediatr Adolescent Gynecol* 2003; 16: 361-3.
3. Caldwell J, Gastonia NC. Foreign body in the vagina for twenty years. *Amer J Obstet Gynecol* 1953; 66: 899.
4. McAllister DW, Gusdon JP. Vaginal foreign body of long duration in a child. *Amer J Obstet Gynecol* 1973; 115: 278.
5. Smith YR, Berman DR, Quint EH. Premenarchal vaginal discharge: findings of procedures to rule out foreign bodies. *J Paediatr Adolescent Gynecol* 2002; 4: 227-30.
6. Caspi B, Zalel Y, Katz Z, Appleman Z, Insler V. Role of sonography in the detection of vaginal foreign bodies in young girls: the bladder indentation sign. *Pediatr Radiol* 1995; 25: 60-1.
7. Kihara M, Sato N, Kimura H, Kamiyama M, Sekiya S, Takano H. Magnetic resonance imaging in the evaluation of vaginal foreign bodies in a young girl. *Arch Gynecol Obstet* 2001; 265: 221-2.



Fig. 1. Inflamed vulva with the foreign body which was removed from the vagina.