



## Consensual coital vaginal laceration in hypovolaemic shock: A report of two cases

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### Abstract

**Background:** Certain life-threatening complications and morbidities may occur following consensual sexual intercourse which may not be commonly experienced in clinical practice. One of such complications is hypovolaemic shock resulting from profuse bleeding.

**Methods:** Two cases of vaginal laceration complicated by hypovolaemic shock following consensual sexual intercourse are presented.

**Results:** Both patients had resuscitation with intravenous fluid, blood transfusion and subsequent examination under anaesthesia with repair of laceration in theater. Post-operative recovery period was uneventful and they were both discharged after proper counselling.

**Conclusion:** Bleeding from coital laceration could be life threatening. Prompt treatment should be instituted in such cases.

Key words: Coital laceration, Shock

### Introduction

The act of coitus though enjoyable, may sometimes be associated with unintended complications. These complications could be minimal or self-limiting; however, it may sometimes result in severe morbidities and could even be life threatening. Some uncommon complications from coital laceration include: peritonitis, bowel evisceration, haemoperitoneum, rectovaginal fistula, hypovolaemic shock.<sup>1,2,3</sup>

Coital vaginal lacerations occur commonly in cases of rape/non-consensual intercourse, it can however occur in consensual intercourse owing to a number of factors. Some of the other risk factors that have been associated with coital laceration include: coitarche, peno-vaginal misfit, short vagina, sex during pregnancy or the puerperium, inadequate foreplay, use of sex toys/sex enhancing drugs,

hurried/rough sex, sex in the dorsal position, previous vaginal surgery, vaginal spasm amongst others.<sup>4</sup>

We present two cases of coital vaginal laceration presenting in hypovolaemic shock.

### Case 1

An 18-year-old nulligravida presented at the accident and emergency unit with history of vaginal bleeding which was preceded by sexual intercourse with her partner. Intercourse was consensual. There was associated dizziness, and she had an episode of fainting. This was not the first sexual experience with her partner, however there was no adequate foreplay prior to penetration. and she was in the dorsal position during the sexual intercourse. There was no previous history of vaginal injuries and no history of bleeding disorders. On examination, she was anxious, pale and dehydrated. She had a pulse rate of 120 beats per minute, blood pressure of 80/60mmHg and respiratory rate of 22 cycles per minute. Vaginal examination revealed a transverse laceration in the posterior vagina fornix with minimal oozing. An assessment of coital vaginal laceration in hypovolaemic shock was made. She

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was resuscitated with intravenous fluid, and commenced on intranasal oxygen. Packed cell volume was 15%. The vagina was packed with pad for tamponade and she was counselled on the findings and the need for a repair to be done under anesthesia.

## Case 2

A 19-year-old nulligravida was rushed to the accident and emergency unit with history of vaginal bleeding following consensual sexual intercourse with her partner. Bleeding was said to be profuse with associated dizziness but no fainting attack. There was also mild lower abdominal pain. This was not her first sexual intercourse with her partner. There was no history of use of sex toys, sex enhancing drugs, and foreplay was said to be adequate. She was however in the dorsal position during the sexual intercourse. At presentation she was anxious, pale and dehydrated. She had a weak pulse with rate of 120 beats per minute, her blood pressure was unrecordable and her respiratory rate was 28 cycles per minute. There was mild lower abdominal tenderness on abdominal examination, vaginal examination revealed a transverse laceration in the posterior vagina fornix with oozing from the edges. She was resuscitated with intravenous fluid and commenced on intranasal oxygen. Packed cell volume was 22%. She was counselled on the findings and the need for her to be examined under anaesthesia with repair of the laceration.

## Intraoperative findings

A 5-centimeter, and a 4-centimeter transverse laceration on the posterior vaginal fornix was found respectively. In both cases there was no communication between the vagina and the peritoneal cavity and no rectal involvement. The first case was transfused with 3 units of blood and her packed cell volume postoperatively was 28%, while the second case had 2 units of blood and her packed cell volume postoperatively was 30%. Sex education, counselling and psychological support were offered to both patients prior to discharge.

## Discussion

Coital laceration accounts for a significant proportion of non-obstetric cause of injury to the genital tract. The incidence of coital laceration is

however thought to be more than what is commonly reported in literature.<sup>4</sup> This may be attributed to individuals with minimal or self-limiting symptoms who will not present for treatment. Furthermore, some patients with coital laceration may give a pseudo history because of the social embarrassment and possible stigma associated with the condition coupled with our conservative culture regarding issues on sexuality in this part of the world.<sup>5</sup> This may in part be responsible for delayed presentation, and buttresses the need for a confidential approach to be employed when managing patients with this condition.

The risk factor common to both cases presented was sex with the female in the dorsal position, which has been shown to be a sex position implicated in several cases of coital injuries. Bleeding has been shown to be the commonest presenting symptom for coital laceration and this may be minimal requiring just observation or minimal intervention. Occasionally, it may be profuse and life threatening.<sup>6</sup> For patients presenting in shock, prompt resuscitation with fluids, repair of laceration and blood transfusion is usually necessary to prevent a fatal outcome. The repair of laceration should be done under anesthesia as this will facilitate patients' relaxation, permit better visualization of the extent of the laceration and also help in excluding other potential complications. These were done for the cases presented.

Coital laceration may sometimes lead to a subtle aversion for sex, particularly if there were life threatening complications and this may have a negative impact on the sexual lives of those affected.<sup>7</sup> There is therefore a need for a multidisciplinary approach in management which should involve the psychologist or sexologist (if available), for proper sex education, counselling and psychological support for patients with coital laceration as was done for both patients presented.

It is also noteworthy, that both cases presented were adolescents; this age group has been shown to have a tendency to be experimental, and are prone to engage in sexual behaviours that could result in undesirable outcomes.<sup>8</sup> Nweke in Abakaliki, South East Nigeria, and Umaru in Maiduguri, North East Nigeria both reported that 67.9% and 45.8% respectively, of patients who presented with coital lacerations were adolescents.<sup>9,10</sup> This calls for a need to scale up age-specific programs on sexual and

reproductive health targeted at adolescents. In conclusion, consensual coital vaginal laceration could present with life threatening haemorrhage. Management should be expedited in such instances to avoid catastrophic outcomes.

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