

Intra Urethral Intercourse: A Report of Two Cases

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INTRODUCTION

Urethral coitus is very rare and in the reported cases, it was mostly presented with urinary incontinence and infertility. Septate vagina and other anomalies of hymeneal orifice are predisposing factors at the time of initiation of sexual activity.⁽¹⁾

Urethral intercourse in the female is very rare. When urethral coitus occurs, it is usually in association with rape or with vaginal atresia or other hymeneal anomalies. We present two cases of urethral coitus in presence and absence of a genital anomaly.

CASE 1

A 21-year-old woman was presented with a history of severe urinary incontinence since marriage (1.5 years earlier). She sought medical help for severe dyspareunia, infertility and recurrent urinary tract infection (UTI) and were simultaneously evaluated for probable diagnosis of infertility. She used sanitary pads to keep herself dry. Examination revealed that she had a 2.2 cm urethral wall with a tear extending from the urethral meatus proximally to bladder neck distally (Figure 1). Normal ovaries, uterus and vagina were confirmed by both physical

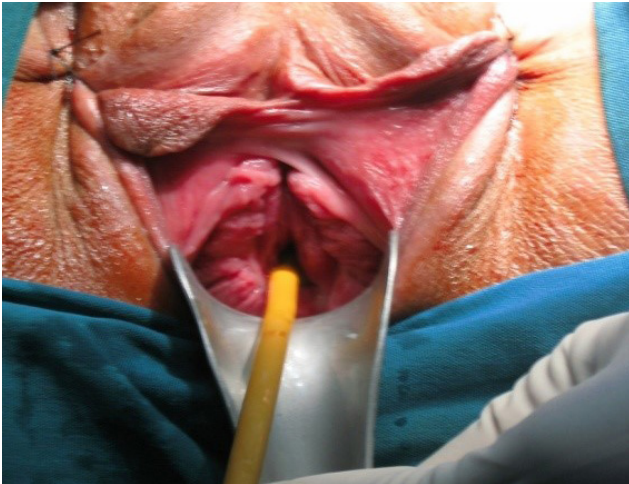


Figure 1. Urethral wall with a tear extending from the urethral meatus proximally to bladder neck distally.

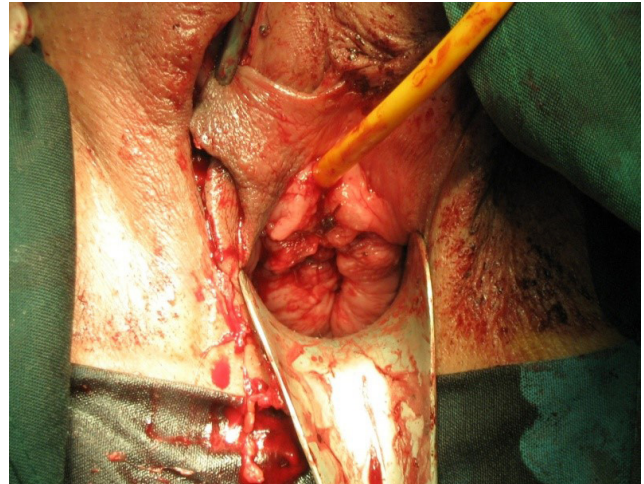


Figure 2. The neo-urethra had adequate length and caliber.

examination and ultrasonography.

Cystoscopy was done under anesthesia during which the urethra and the bladder neck was found to be damaged. Under general anesthesia and in lithotomy position, a 3.5 cm vertical inverted U incision was made just in the proximal extent of urethral laceration and vaginal wall dissection of the urethra and opening of bladder neck. The paravaginal flap was sutured (with 4-0 Vicryl placating sutures) to the edge of the parallel distal incisions over the catheter to form the new urethra. The classic rectus fascial graft was passed around the urethra and reinforced with Martius flap and epithelium of vaginal wall was approximated trough the entire of urethra (Figure 2). The catheter was removed 10 days after operation. She was followed up for 2 years and remained continent.

CASE 2

A 19-year-old woman presented with history of enuresis, frequency, recurrent UTI and also very painful coitus (dyspareunia) and infertility after two years of marriage. She was evaluated earlier with intravenous urography and ultrasonography elsewhere, which were reported as normal. The patient was a young woman from a poor family living in a small village. She had prior gynecological and psychological consultation for her problems. The patient had un-

dergone vaginal examination. It revealed a vertical vaginal septum. Resection of vaginal septum was done through the vagina which was about 8 mm thick (Figure 3). However, urethral damage was missed for 1 year later when she referred to our clinic for management of urinary incontinence. Vaginal examination and cystoscopy under anesthesia revealed an open bladder neck and laceration of entire length of the urethra (Figures 3 and 4) which strongly suggested intra urethral coitus. In an operative setting under general anesthesia, the urethral repair was done with a paravaginal flap. First, the edge of the urethral laceration was freshened. Then the paravaginal flap was sutured to the edge of the parallel distal incisions of the damaged urethra over the 10 French Foley catheter to form the new urethra. As an anti-incontinence surgery, rectus fascia graft was passed around the urethra to maximized urethral closure pressure (Figure 5). The vaginal wall was approximated in the midline to cover the neourethra.

DISCUSSION

Among the causes of stress urinary incontinence (SUI) in women, trauma and urethral loss are extremely rare. The most important causes of urethral laceration and loss of sphincteric mechanism include the impacts associated with pelvic fractures, puerperal trauma and iatrogenic causes.



Figure 3. Vertical vaginal septum (partially excised with gynecologist) and patulous urethra.



Figure 4. Urethral laceration involves the entire length of the urethra and sphincteric mechanism. Balloon of Foley catheter is exposed at the damaged bladder neck.

^(2,3) Rare cases of urethral rupture was reported after rape or sexual disabuse,^(4,5) but in our first case, despite the existence of a normal genital anatomy, the intercourse was intraurethrally done by the husband that there was no explicit justification for it.

In the second patient, the vertical vaginal septum can be propounded as a limiting factor of vaginal space and the background for urethral rupture. To our knowledge, this is the first case of urethral intercourse associated with vertical vaginal septum. In particular, the occurrence of most of the cases of intercourse through urethra were related to Mullerian anomalies.^(1,6) The reported anomalies include Mayer-Rokitansky syndrome,⁽⁷⁾ microperforated hymen,⁽⁸⁾ and transverse vaginal septum,⁽⁹⁾ but also there is some reports of urethral coitus despite normal genital anatomy.⁽¹⁰⁻¹²⁾

In all of these patients, in addition to dyspareunia and/or unsatisfied coitus, patient has also complained from sever urinary incontinence.^(7,10) In our reported patients, urethroplasty with paravaginal flap and classic sling⁽¹⁰⁾ were also done for repairing the patients urethra. Their outcomes were successful for SUI treatment and patients' urinary symptoms were solved. Teaching the correct way of intercourse to patients' partner and correction of the patient anatomical impairment, should also be performed for dyspareunia treat-

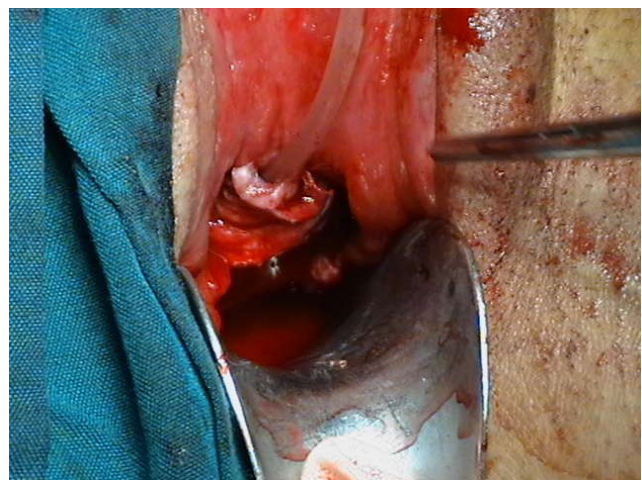


Figure 5. Rectus fascia graft is passed around the urethra to maximizing urethral closure pressure.

ment and should be followed up carefully.

CONFLICT OF INTEREST

None declared.

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