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Severe Sexual Disorders in A 25-Year-Old Housewife A Case of Concealed Absent Vagina

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Abstract

Vaginal agenesis is a rare congenital anomaly that may present with primary amenorrhea and inability to achieve vaginal intercourse despite normal secondary sexual characteristics. We report the case of a 25-year-old newly married woman who presented with severe sexual dysfunction due to an absent vagina, which she had concealed from her husband. Clinical examination, pelvic ultrasonography, and hormonal evaluation confirmed vaginal and uterine agenesis with small ovaries. She underwent serial vaginal dilatation with minimal improvement and was counselled regarding neovagina reconstruction and psychological support. However, she declined disclosure of her diagnosis to her husband and was subsequently lost to follow-up. This case highlights the medical, psychological, and ethical challenges associated with vaginal agenesis and underscores the importance of early diagnosis, comprehensive counselling, and multidisciplinary management.

Key Words: *Sexual Disorders, Marriage, Absent Vagina, Concealed, House Wife, Pastor, Challenges, Nigeria.*

1. Introduction

An absent vagina is clinically known as vaginal agenesis or vagina atresia. It is a rare congenital condition where the vagina fails to develop fully in the embryonic period. It is often addressed using non-surgical vaginal dilators or surgical reconstructive technique. The causes are Mayer-von-Rokistansky–kuster-hauser syndrome, a condition in which the vagina and uterus are absent or underdeveloped, though the ovaries may function normally [1]. Another cause is androgen insensitivity syndrome (ais)—a condition where a genetic male develops a female physical appearance but lacks internal reproductive structures such as the uterus , fallopian tubes, ovaries, and the vagina. The ovaries function normally; individuals typically go through normal female puberty and develop secondary sexual characteristics. Symptom varies depending on the presence of uterus or its absence [2]. The goal of treatment is to create a functional vagina to allow for comfortable sexual intercourse and normal menstrual flow if the uterus is present, or to perform vaginoplasty or neovagina surgery. This case report highlights sexual challenges in a young housewife who concealed her condition of absent vagina and marry a pastor.

2. Case report.

A 25 - year old married woman was referred to our gynaecological clinic with history of inability to have sex with her newly wedded husband due to inability to penetrate vaginal sex. She is third out five siblings, but none female siblings have this problem and they were married with children. She has never attained menarche, but secondary sexual characteristics well developed. She made several attempts at having sex with other male friends but were never successful. Her mother and one of her siblings were aware. A pastor from one of the orthodox churches fell in love with her and eventually wedded but they were unable to have vagina sex. She never allowed her husband to accompany her to the hospital and had told the man that the difficulty was due to her virginity. Her intention was to leave the man quietly without disclosing her condition to him.

Examination revealed a pretty tall lady of 1.56m tall, well developed breast but constitutionally small. Normal axillary and pubic hairs. Labia majora and minora were present but small. There was vagina dimple beneath the urethral orifice that ended blindly. Pelvic ultrasound revealed absent vagina and uterus. The ovaries were present but small in size measuring 1cmx1cm bilaterally. Hormonal assay was done that revealed elevated lh and fsh but low oestrogen and progesterone. She had serial dilatation exercises using graded dilators (test tubes). She had two follow up visits with mild improvement. She was counselled on the need for the construction of neovagina, but she was subsequently lost to follow up.

3. Discussions

An absent vagina is clinically known as vagina atresia or vagina agenesis. It is a rare congenital condition where the vagina fails to develop fully in the embryonic period. The causes are Mayer Rokitansky–Küster–Hauser syndrome, a condition in which the vagina and uterus are absent or underdeveloped, though the ovaries may function normally. It is seen in about 1 in 5,000 females when Mullerian ducts fail to develop properly during fetal growth [3]. The condition falls under Mullerian agenesis. The symptoms are that of primary amenorrhoea, abdominal pain if the individual has a partially developed uterus that produces menstrual blood but has no exit. The anatomy of external genitalia typically looks normal, but the vagina may be absent, or end in a shallow dimple. In over 90% of cases, the uterus is absent or significantly under developed. Another cause is androgen insensitivity syndrome (ais); a condition where a genetic male develops a female physical appearance but lacks internal reproductive structures like the uterus, fallopian tubes and the ovaries [4].

The common symptoms depend on whether the ovaries function normally, individuals typically go through normal female puberty and develop secondary sexual characteristics. The symptoms varies depending on whether the uterus is present or not. This lady has well developed breast but constitutionally small. Normal auxiliary and pubic hairs were present. Labia majora and minora were present but small. There was a suspected vagina dimple that ends blindly. Pelvic ultrasound done revealed absent vagina and the uterus. The ovaries were identified but atretic. The hormonal assay test done, revealed elevated luteinising and follicle stimulating hormones. Oestrogen and progesterone were equally low. This lady probably has Mayer- rokistansky-kauster-hauser syndrome. She probably deceived the husband into marriage fully aware that she has no vagina and concealed it throughout the time she was referred to the gynaecological clinic and throughout the non-surgical treatment. She had serial dilatation exercise using graded dilators (test tubes) with little improvement. She was also advised to disclose the diagnosis to her husband but persistently refused rather her plan was to leave the husband quietly. She was worked up for neovagina surgery, but she was lost to subsequent follow up despite adequate counselling. This case report highlights a peculiar and complex sexual problem in an orthodox Christian marriage where trust may be a blind binding force for one of the couples.

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