



Figure 1. Evidence of massive haemoperitoneum on laparoscopy.

uneventful and she was discharged home on the 5th day after the operation.

Discussion

Although vaginal lacerations following sexual intercourse are common, posterior vaginal fornix rupture communicating with the peritoneal cavity, causing massive haemoperitoneum is a rare entity. Severe coital injuries are more likely to occur following rape, use of objects as sexual tools, violent or hurried sex and intercourse under the influence of drugs and alcohol. Size disparity between the genital organs, young age, certain positions during intercourse, postmenopausal and post total abdominal hysterectomy status and congenital anomalies of the vagina are also risk factors. Such injuries are reportedly more common at the extremes of ages but can be seen in women of childbearing age (Manchanda and Refaie 2005). In this case report, the age of the patient and prone position during intercourse were the likely contributory factors. Bleeding from posterior vaginal fornix rupture as a result of coital injury may be revealed or concealed.

A review of the literature has shown that severe upper vaginal injuries following coitus, causing massive haemoperitoneum, pneumoperitoneum, or haemo-pneumoperitoneum are becoming a common medical emergency.

Cases with a misleading history or inadequate vaginal examination have been misdiagnosed as surgical acute abdomen or menorrhagia because upper vaginal injury causing haemoperitoneum is not considered in the differential diagnosis (Manchanda and Refaie 2005; Lal et al. 2001).

It is important that in females who present with an acute abdomen, with or without vaginal bleeding, following coitus, the differential diagnosis should include severe upper vaginal injury.

This case aims to highlight the need for doctors to have a low threshold of suspicion of severe upper vaginal injury in women who present with an acute abdomen, with or without vaginal bleeding after an act of intercourse.

For the diagnosis to be established a proper gynaecological history and examination by a senior and experienced gynaecologist should be performed.

Bowel or omentum may prolapse through a posterior vaginal wall tear (Lal et al. 2001). Rectal injury, resulting in recto-vaginal fistula may result (Sau et al. 1993). It has been suggested that a rectal examination should routinely be performed in the presence of a posterior vaginal wall tear following coitus.

In teenage girls an accurate diagnosis is usually more difficult to achieve as there may be failure to volunteer a history of sexual intercourse and examination can be more difficult because of pain. In such cases, need for examination under anaesthesia should be considered.

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Penile jewellery: a cause of post-coital bleeding

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Case report

A 21-year-old nulliparous woman was referred to the colposcopy clinic with a 7 month history of postcoital bleeding. She gave a history of regular menstrual cycles and was on the combined pill for contraception. Bleeding occurred with every act of intercourse varying from mild to heavy loss. There was no inter-menstrual bleeding and no dyspareunia.

Colposcopic examination revealed a healthy nulliparous cervix. However, on the vagina there was evidence of multiple deep and extensive abrasions on the vaginal walls. She had been seen by her GP 3 months earlier who performed a cervical smear, the report of which was normal. In view of the persistent nature of the postcoital bleeding, she was referred to the genito-urinary clinic and investigations there revealed no pathology. She was then referred to the colposcopy clinic. The extensive nature of the vaginal

abrasions and lacerations were discussed with the patient in an attempt to explore the possible aetiology. She then admitted that her boyfriend wore penile jewellery of the 'Prince Albert' type. This information shed light on the aetiology of the post-coital bleeding as well as the bizarre vaginal findings on colposcopy. She was counselled about removing the jewellery prior to intercourse and discharged.

Discussion

Body piercing as a fashion fad has been on the increase worldwide and has become a significant health problem (Esen 2004). Intimate body piercing (nipples, penis, scrotum, foreskin, labia and clitoris and perineum) has also gained in popularity. It is commonly acquired for sexual gratification (Moser et al. 1993; Miller and Edenholm 1999), but may carry significant health consequences. Apart from the possible complications which may arise as a direct result of the procedure, there is a significant risk of infections with intimate body piercing (Khanna and Kumar 2000). For men, there is also the increased risk of contracting sexually transmitted diseases and complications like avulsion of the jewellery and urethral rupture have been reported (Higgins et al. 1995; Hall and Summerton 1997). In the case presented here, inappropriate investigations and treatment could have resulted if the history of penile jewellery in the partner had not been elicited. It is of note that there had already been one referral to the genito-urinary clinic. Clinicians need to be alert as to the possible impact intimate body piercing may have on patients in order that inappropriate and unnecessary treatment is avoided (Modest and Fangman 2002). There is evidence that healthcare personnel lack knowledge about body piercing and such lack of knowledge may be of importance when patients with body piercing, intimate or otherwise, seek medical care (Meyer 2000; Khanna et al. 1999). It is important that young men and women are educated about the risks genital

piercing may pose in terms of sexually transmitted diseases and indeed, transmission of HIV and hepatitis. As shown in this case, there is also a risk of misdiagnosis and inappropriate treatment. There may be also issues regarding contraception as condoms can easily be torn by these devices. The history of penile jewellery in partners of women presenting with post-coital bleeding needs to be sought in the management of the condition.

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Appendiceal mucocele misdiagnosed as an ovarian tumour

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Case report

A 56-year-old postmenopausal woman was referred to the gynaecological outpatient department with a history of vaginal bleeding. Vaginal examination revealed right adnexal fullness. An endometrial biopsy failed due to a stenosed cervix. A transvaginal scan showed an endometrial thickness of 4.5 mm and a bizarre mass in the right iliac fossa measuring 100 × 39 × 41 mm largely consisting of solid tissues in a laminated fashion (Figure 1).

A CT scan showed a right adnexal cyst with a few strands of enhancing tissue at the centre of the cystic lesion, most likely to be ovarian in origin. Malignancy could not be excluded (CA125 normal). Therefore, hysterectomy and salpingo-oophorectomy was planned. At laparotomy, the uterus and ovaries were normal and a large appendiceal mucocele measuring 10.5 cm × 6 cm was noted. An appendicectomy was performed. Endometrial biopsy produced no specimen. Histology confirmed a mucocele of the appendix.

Discussion

Mucocele of the appendix occurs when the proximal end of the lumen becomes occluded by a stricture, tumour, inflammation or faecolith.

Characteristic radiological features are described which aid in the diagnosis. Ultrasound appearances of an elongated echo poor mass without posterior enhancement or lateral shadowing (Sasaki et al. 2003), bottle- or banana-shaped mass with repeated sedimentation of mucinous material causing thin layers resembling onion skin (Degani et al. 2002) and calcification in the walls have been described.

On CT scan, spherical or elongated cystic lesion attached to the wall of the caecum with mural calcification (Zissin et al. 1999), mural calcification on X-ray and caecal filling defect on barium enema (Degani et al. 2002) have also been described.