Clinical-Scientific Notes

Labial fusion causing acute urinary retention in a young adult: A case report

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Key words: Labial fusion, urinary retention, young adult.

Introduction

Labial fusion is defined as a partial or complete adherence of the labia minora. The labia minora adhesion is a common paediatric gynaecological problem, and occurs more frequently between three months and three years.[1] Adhesions of the labia are rare in adult population. There are a few cases in the literature. The aetiology of labial adhesion probably relates to vaginal inflammation or irritation, and is associated with low oestrogen status.[2] Labial fusions may be caused by infections, inflammatory conditions, dermatological conditions, lack of sexual activity, local trauma, genital circumcision and recurrent urinary tract infections.[3] If the labial adhesions are severe or related to urinary problems, surgical treatment should be considered.

Case report

An 18-year-old girl presented to our hospital's emergency service for acute urinary retention. Pelvic examination demonstrated severe labial fusion (Fig. 1) and globus vesicalis. Immediate release of retention was achieved via a urethral catheterisation. Pelvic ultrasonography showed normal urinary system, normal uterus and normal ovaries. She had normal secondary sexual characteristics and regular menstrual history also. Even though the patient did not mention about sexual abuse, the possibility that the adhesions were caused by trauma could not be totally excluded. Her hormonal status was normal. She underwent separation of labial fusion under general anaesthesia. Labial adhesions were lysed and mucosal sutures were used to prevent recurrence. A hysteroscopy was performed, and showed normal vaginal and cervical anatomy. Postoperatively the patient was instructed to apply oestrogen cream locally. Vulvar tissue was healthy at 5-months follow-up.

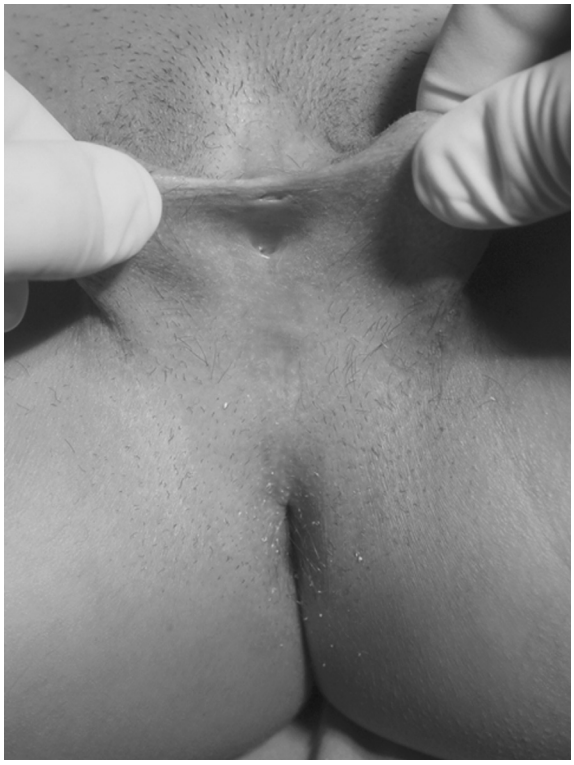

Figure 1 Labial fusion with a small opening.

Conclusion

The treatment of adhesions with a topical oestrogen cream is usually successful and surgery is rarely necessary.[4] Surgical correction may be necessary when medical treatment fails. Our surgical procedure was similar to the one described by Nurzia *et al.*[5] Suturation of the mucosal margins will prevent recurrence of this problem. We decided to report this rare case, as we thought that it could contribute to the literature.

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Bioidentical testosterone cream: A rare cause of postmenopausal virilisation

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Key words: bioidentical hormones, testosterone cream, virilisation.

Bioidentical hormones are increasingly used as an alternative to hormone therapy (HT) for distressing menopausal symptoms.[1] We report two women with virilising symptoms from compounded testosterone cream and discuss the need for more general awareness of risks associated with these preparations.

Case 1

Mrs LM, with no history of androgen excess symptoms or menstrual irregularity, presented at age 60 with an 18-month history of acne and facial hair requiring two-weekly electrolysis. She underwent bilateral oophorectomy and hysterectomy ten years previously for menorrhagia, and two six-monthly 100 μg testosterone implants were used postsurgery to sustain libido. No further HT was used until three years prior to presentation when testosterone cream (compounding pharmacy, 0.1 mg/mL) was commenced daily for low libido. Examination revealed a lean woman with mild acne, facial hair and significant clitoromegaly (grade 2/4).

Plasma androgen levels were as follows: total testosterone (T) 33 nmol/L (N 0.5–2.5), free T 861 pmol/L (N 8–58) and DHEAS 5.2 μmol/L (N 0.7–6.5). A computerised axial tomogram of the adrenals and ovaries was normal.

The testosterone cream was discontinued; plasma total T fell to normal female levels (0.6 nmol/L).

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Case 2

Mrs LN, a healthy 59-year-old woman, presented in 2003 with poor libido while taking a combined oestrogen–progesterone HT. Baseline T was < 0.5 nmol/L (free T < 9 pmol/L). She was prescribed testosterone, progesterone and oestrogen creams in addition to HT, and applied testosterone cream (0.1 mg/mL) liberally to the clitoris (by patient choice) twice daily. However, in July 2007 routine endocrine testing demonstrated elevated plasma testosterone (37.9 nmol/L) and muscle hypertrophy on clinical examination. The patient discontinued testosterone cream and plasma T normalised to 1.9 nmol/L within 2 weeks.

Discussion

Low libido is a common symptom. The FDA has approved 1% testosterone cream (Andro-Feme, Lawley Pharmaceuticals) for women after two clinical trials demonstrated improved well-being and sexual desire without significant adverse effects or elevation of plasma testosterone.[2,3] However, in Australasia (with the exception of Western Australia where androfem is available) there are no registered preparations for low libido in women, although many alternative remedies are marketed.

Bioidentical hormones are not registered medicines and may be imported without restriction, enabling pharmacists to compound these hormones into various vehicles, provided they are prescribed by a registered medical practitioner. There is no quality control of dose or purity of bioidentical hormone manufacture, and FDA trials have demonstrated 34–90% failure of quality control compared with 2% in pharmaceutical products.[4] Inconsistencies in active hormone dose may cause variation in bioavailability.

