International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Sareen RK et al. Int J Reprod Contracept Obstet Gynecol. 2026 Feb;15(2):750-751
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20260204

Case Report

A rare case of secondary gynaetresia after face-to-pubes birth managed by vaginoplasty

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Received: 17 December 2025
Revised: 15 January 2026
Accepted: 16 January 2026

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ABSTRACT

Postpartum vaginal stenosis is an extremely rare but distressing complication following vaginal delivery. We report the case of a 25-year-old para 1 woman who developed secondary gynatresia after a face-to-pubes vaginal delivery complicated by extension of episiotomy and vaginal wall tears. The patient presented two months postpartum with inability to resume sexual intercourse. Examination revealed a fibrous constricting band at the vaginal introitus with markedly reduced vaginal caliber. She was successfully managed with surgical adhesiolysis and vaginoplasty followed by regular postoperative vaginal dilation. Early diagnosis and timely surgical intervention resulted in complete symptomatic relief. This case highlights the importance of careful repair of obstetric lacerations and vigilant postpartum follow-up to prevent long-term sexual morbidity.

Keywords: Vaginal stenosis, Postpartum vaginal stenosis, Episiotomy, Vaginal delivery, Vaginal dilation, Gynatresia, Face-to-pubes birth, Vaginoplasty

INTRODUCTION

Vaginal stenosis, or gynatresia, is a rare but significant complication following vaginal delivery and remains poorly documented in the literature.[1-3] Perineal tears sustained during childbirth, improper approximation of tissues during episiotomy or perineal repair, and subsequent fibrosis may progressively narrow the vaginal canal.[4] In a retrospective study of 126 cases of acquired gynatresia, nearly 25% were attributed to birth-related injuries, pelvic infections, or postoperative scarring, underscoring obstetric trauma as a major etiologic factor.[4]

We present the case of a 25-year-old para 1 woman who developed secondary gynatresia following a face-to-pubes delivery, leading to dyspareunia and inability to resume sexual intercourse.

CASE REPORT

A 25-year-old para 1 woman reported to the gynecology clinic two months after delivery with complaints of inability to perform sexual intercourse since childbirth. Her obstetric history revealed that she had undergone a vaginal delivery with a medio-lateral episiotomy. The fetus was delivered by a face-to-pubes presentation, resulting in extension of the episiotomy and associated vaginal wall tears, which were repaired immediately after delivery. The postpartum period was uneventful, and she was discharged on the third day in good condition.

On examination, the patient was of average build. Local examination showed normal external genitalia. Vaginal examination revealed a fibrotic band at the introitus, admitting only one finger with difficulty, with a vaginal depth of approximately 3 cm. Beyond the fibrotic

constriction, the remaining vaginal canal felt normal. A diagnosis of secondary vaginal stenosis was made.

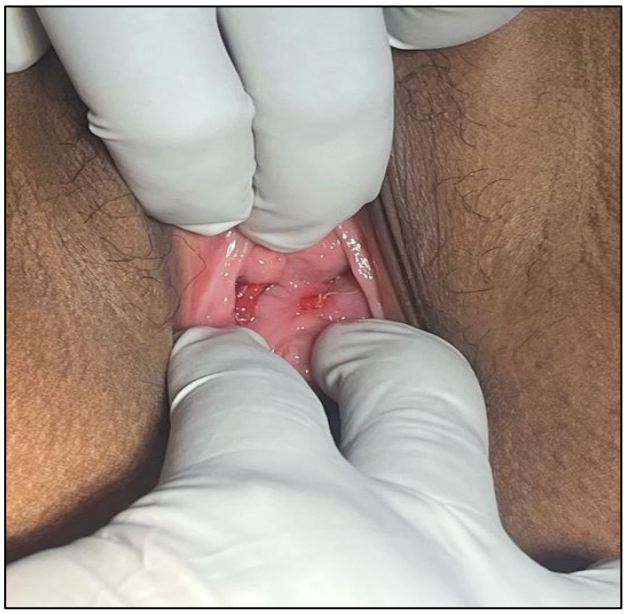

Figure 1: Normal external genitalia with a fibrotic band at the introitus.

The patient underwent excision of the vaginal adhesions and successful vaginal reconstruction. Postoperative review at one week showed good healing and no complaints.

DISCUSSION

Although most cases of vaginal stenosis arise following pelvic or vaginal radiotherapy, it may also occur secondary to hypoestrogenism, infection, chemical injury, or postpartum trauma.[6] Das et al reported a case of vaginal adhesions following cesarean section for obstructed labor.[1] Gupta et al documented vaginal stenosis due to chemical vaginitis presenting with amenorrhea and dyspareunia, treated effectively with adhesiolysis and vaginal reconstruction.[2] Olamijulo and Ogedengbe described successful excision of adhesions and postoperative dilation in a 19-year-old woman who developed vaginal stenosis following unsutured vaginal tears during home delivery.[3]

In the present case, vaginal adhesiolysis was performed by making a circular incision over the constricting ring, dissecting the vaginal epithelium away from the scar until adequate caliber was restored, re-anastomosing the vaginal edges, and inserting a vaginal mold. This technique is consistent with methods described in previous reports.[3-6] The patient was discharged after two postoperative days with advice to change the mold every 48 hours. Follow-up at one week and six weeks showed good healing with no dyspareunia.

Postpartum follow-up must emphasize evaluation of episiotomy wound healing, recognition of early infection, and inspection to ensure no packing material has been inadvertently retained.[7] Early recognition allows for simple excision before dense fibrosis develops.[7] In our patient, the stenosis likely resulted from obstetric trauma compounded by episiotomy extension and subsequent fibrosis, a mechanism consistent with standard obstetric texts.[5,6] Surgical adhesiolysis combined with structured postoperative vaginal dilation remains the most effective treatment strategy.[1,3,6]

CONCLUSION

Postpartum vaginal stenosis is an uncommon but potentially preventable cause of significant sexual dysfunction. This case demonstrates that inadequate healing following episiotomy extension and vaginal tears can result in secondary gynatresia even in the absence of infection or radiotherapy. The report advances current knowledge by highlighting face-to-pubes delivery with episiotomy extension as a specific risk factor and reinforces that early clinical suspicion, meticulous examination, and timely adhesiolysis with postoperative dilation can completely restore vaginal function. Strengthening postpartum surveillance of perineal wounds and early referral of symptomatic women can prevent long-term morbidity and improve quality of life.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Sareen RK, Anand P, Sehgal C. A rare case of secondary gynaetresia after face-to-pubes birth managed by vaginoplasty. Int J Reprod Contracept Obstet Gynecol 2026;15:750-1.