Perineoplasty and Vaginal Advancement Flap for Vulvar Granuloma Fissuratum

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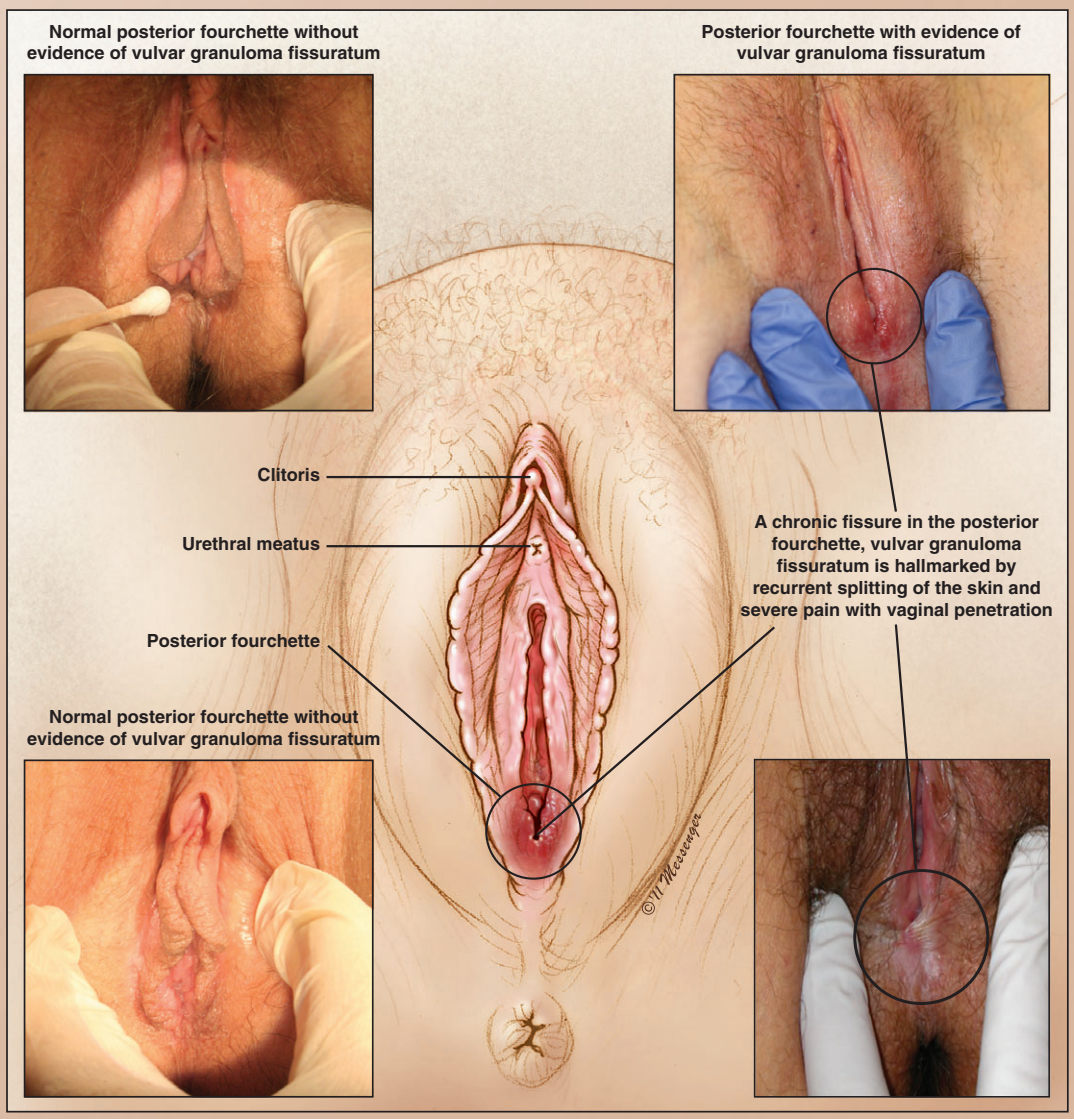

FIGURE 1

Vulvar granuloma fissuratum of the posterior fourchette occurs most commonly from vulvar atrophy and inflammatory vulvar dermatoses, such as lichen sclerosus [1]. It may occur with hypertonic pelvic floor muscles and following a poorly healed episiotomy repair. Diagnosis is made by the presence of a fissure in the posterior fourchette associated with patient description of painful, repetitive fissuring, tearing, splitting, or bleeding of the posterior fourchette with attempted vaginal penetration and/or following vaginal examination. Medical treatments include avoidance of contact irritants, topical corticosteroid, topical hormones, and vaginal dilators. Surgery is offered if conservative medical treatments result in insufficient improvement.

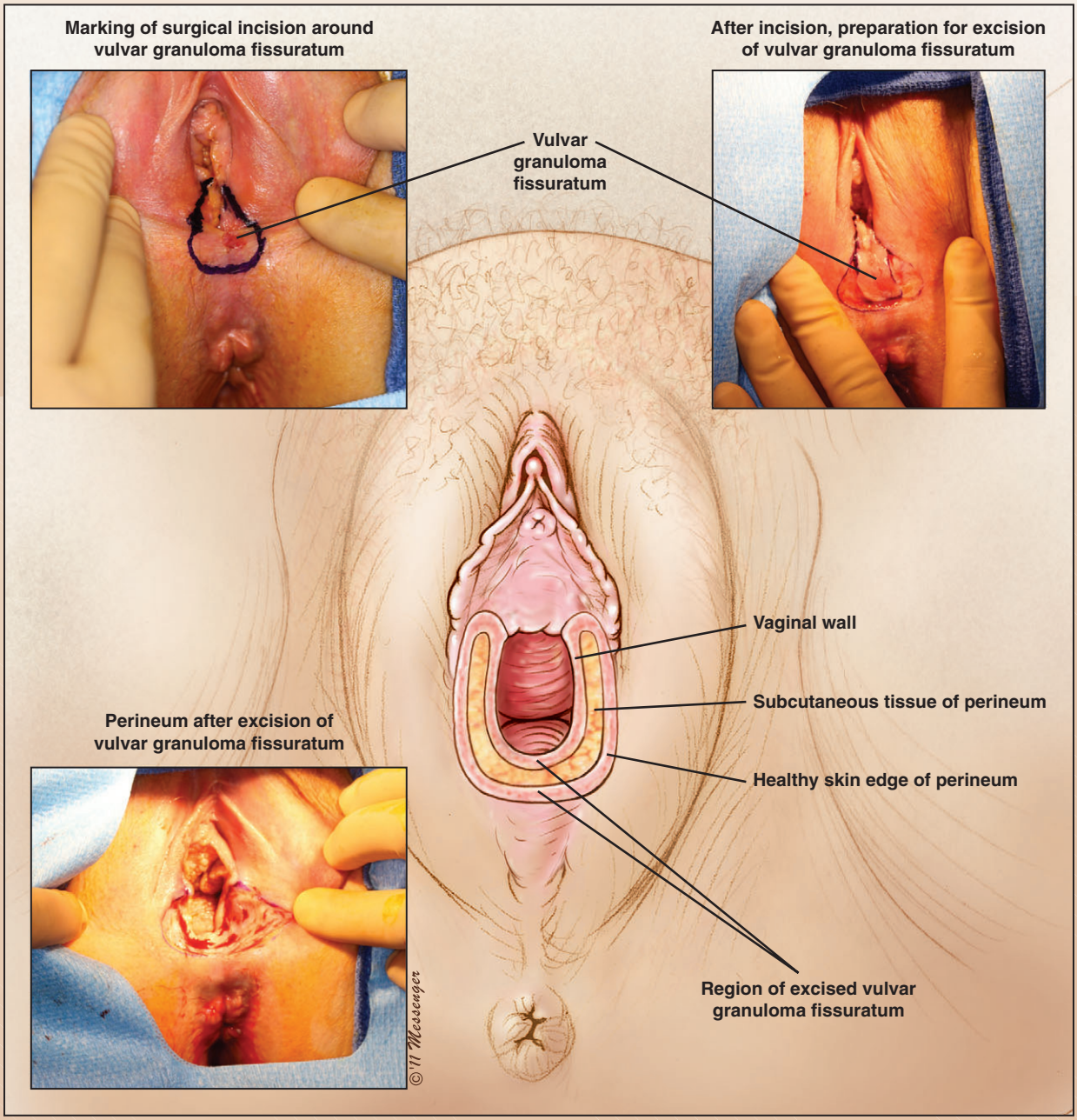

FIGURE 2

Definitive surgical excision of the vulvar granuloma fissuratum with superficial perineoplasty and vaginal advancement flap is herein described. The surgical principle to prevent recurrence of the fissure is that healthy perineal skin needs to be anastomosed to a tension-free, healthy vaginal advancement flap. To ensure complete excision of the vulvar granuloma fissuratum lesion, tension is placed on the posterior fourchette to reproduce the extent of the fissure. The excision area (blue surgical marker) includes hymenal tissue in the posterior vaginal wall and extends generously (at least 1 cm in all directions) around the vulvar granuloma fissuratum lesion.

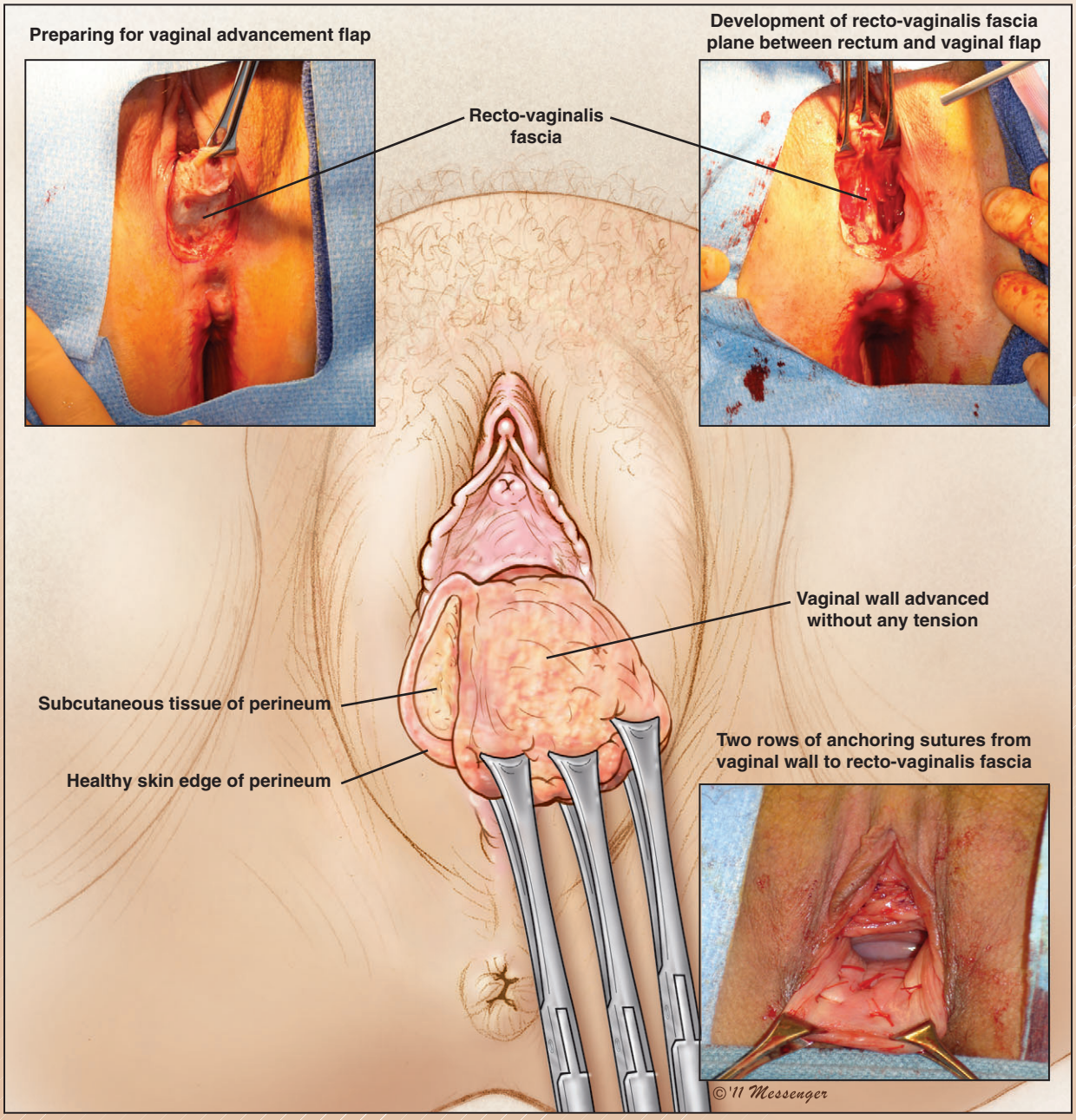

FIGURE 3

The distal posterior vaginal wall is grasped with Allis clamps. The rectovaginalis fascia is dissected to allow for 3–4 cm of vaginal wall advancement without tension.

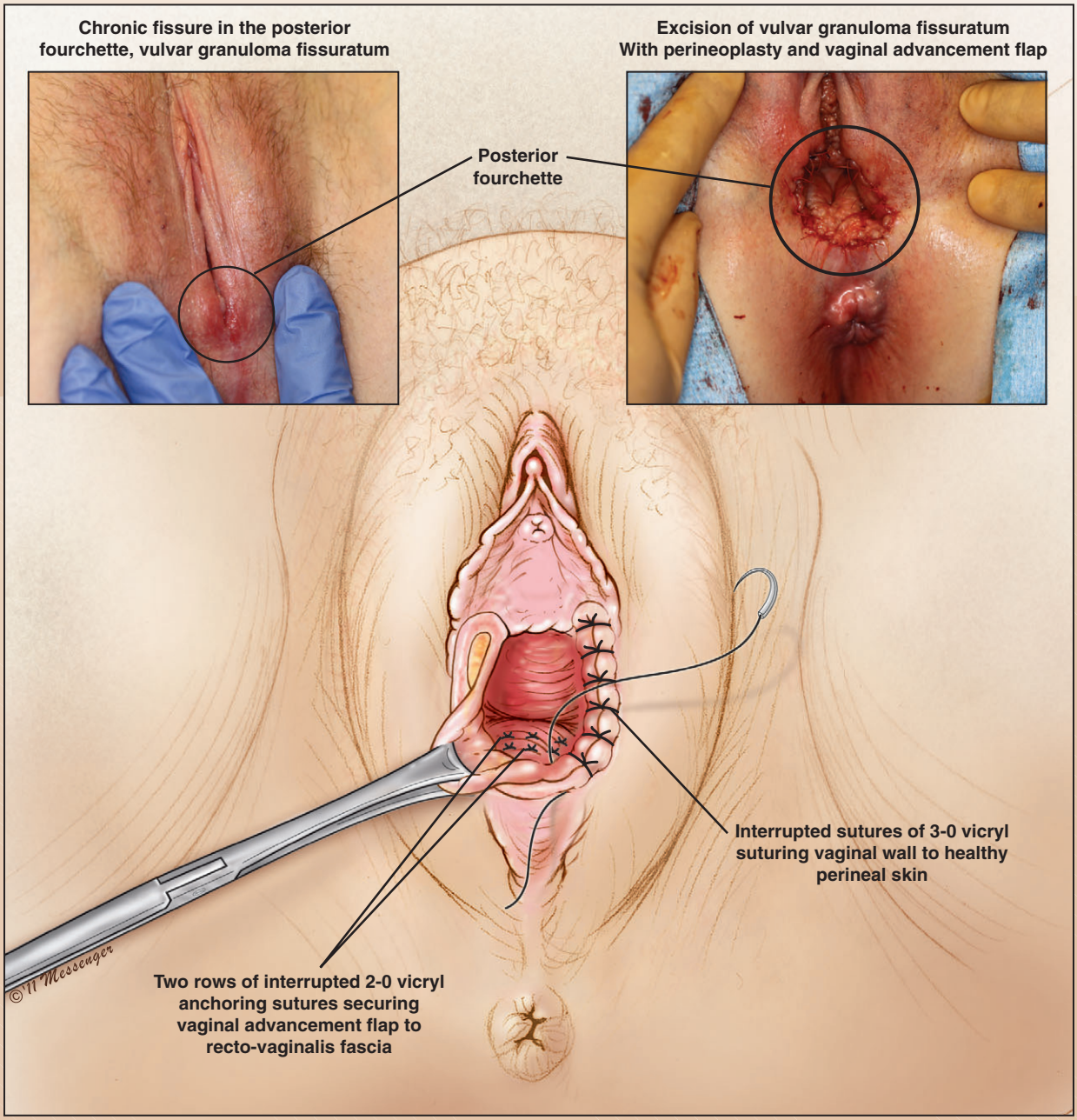

FIGURE 4

Two rows of three individual interrupted anchoring 2-0 vicryl sutures are passed in a vertical mattress technique from the rectovaginalis fascia to the vaginal wall and from the vaginal wall back to the rectovaginalis fascia and then tied. Avoidance of horizontal closure sutures will prevent vaginal introital narrowing. The healthy vaginal wall is subsequently sutured to the healthy perineal skin using 3-0 vicryl.

Reference

1 Rouzier R, Haddad B, Deyrolle C, Pelisse M, Moyal-Barracco M, Paniel BJ. Perineoplasty for the treatment of introital stenosis related to vulvar lichen sclerosus. Am J Obstet Gynecol 2002;186:49–52.