GLOBAL AND SEXUAL QUALITY OF LIFE IN 130 PATIENTS WITH MRKH SYNDROME: A COMPARATIVE STUDY BETWEEN SURGICAL VERSUS NON SURGICAL MANAGEMENT OF VAGINAL AGENESIS

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Background
- MRKH syndrome is a rare disease affecting 1/4500 females.
- The patients have 46 XX karyotype, normal ovarian function and uterine and vaginal agenesis (VA)
- VA management aims to help sexual life and can be non surgical (dilatations) or surgical (various types of vaginoplasties)

Objectives
Our aim was to compare dilatations versus surgery in terms of global and sexual quality of life and anatomical results in a multicentric population of MRKH syndrome.

Subjects and Methods
We realized a multicentric observational study included 130 patients older than 18, at least one year after completing vaginal agenesis management. They aged 26.5 years (18-41). All had medical evaluation including normalized pelvic exam, and filled WHOQOL-BREF (General Quality of Life), FSFI and FSDS-R (Sexual QOL) scales.

Results
- 34 patients (40.5%) had complications, needing 20 additional procedures in 17 patients. Stenosis (23%), hemorrhage (21%), myofacial and vestibular pain (17.6%, n=6), pelvic inflammatory embolism (6.8%, n=2), bowel adhesions (2.9%, n=1), others (11%, n=4)
- 17 patients had an abnormal pelvic exam (introitus stenosis, vaginal narrowing, myofacial pain syndrome)
- 49 patients had dyspareunia, significantly more often after sigmoidovanaginoplasty (70%, p=0.014) compared other techniques.

Anatomical results
Vaginal size: 10.17 cm (SD = 1.77)

- less than 6.5 cm n = 13 (23.8 %)
- less than 9 cm n = 30 (30.8 %)

Surgery 11 ± 1.7
Dilatations 9,25 ± 1.9
Intercourse 11 ± 1.8

p = 0.037
p = 0.007

Vaginal length was significantly lower after dilatations and after peritoneum epithelium techniques in the surgical group, but remained within normal range (9.6 cm (6.2-12.5), Liyod, BJOG 2005)

Sexual Distress (FSDS_R):

Sexual distress was very high in all MRKH patients, unresponsive of the type of management.

Conclusions
Surgery is not superior to autodilatations, bears more complications and should therefore be only a second-line treatment. Sexual distress is high in the majority of patients. Psychological counseling is mandatory at diagnosis and during therapeutical management.