Abstract:
Colporrhexis is a rare phenomena now a days due to improved health care services. We describe one such case, its clinical presentation and management following failure of domiciliary delivery. The rarity of such an incident makes the following case of interest.

Keyword: Colporrhexis, vagina, cervix, vault

Introduction
Colporrhexis¹ is rupture of vaginal vault or rupture of upper third of vagina. It occurs in both pregnant and non pregnant uterus. Coitus and force by foreign bodies in already weakened vagina because of postmenopausal atrophy and previous surgery are the causes in non pregnant uterus. Misdirection of the uterine axis due to pendulous abdomen with divarication of recti, marked obliquity of uterine axis, ventroflexion of uterus, previous weakening of vaginal wall, parity are some of the causes in pregnant uterus. Clinically manifests as similar to rupture uterus, not severe, sudden cessation of labour pain followed by continuous pain, vaginal bleeding, signs and symptoms of shock, bowel or omentum may escape.

Case report - A rare case of colporrhexis
A 22 years old unbooked GPL presented to OBG casualty with labour pains with history of failure of domiciliary delivery. She was 3 days postdated. The previous delivery was conducted by an untrained person. She had no significant medical disorders or previous surgery. On examination her vitals were stable. Uterus was term, acting, head engaged, fetal heart sound was good. Cervix was well effaced, os fully dilated with head on the perineum. Under strict aseptic precautions left mediolateral episiotomy was made. She delivered an alive female baby of weight 3 kg. Placenta delivered by controlled cord traction. After the delivery of the placenta omentum was seen protruding through the vagina and there was torrential bleeding per vaginum. The patient became pale and vitals started deteriorating.
Uterus contracted to 22 wks size. Speculum examination revealed a cervical tear on the left side along with a transverse tear of about 8cm involving the posterior fornix through which omentum was protruding into the vagina. The edges were ragged and multiple lacerations were seen in the vagina. The diagnosis of colporrhexis was made. Vagina packed and patient prepared for on table examination.

Under general anaesthesia patient was examined. The findings were confirmed. An attempt to obtain hemostasis per vaginally failed. So laparotomy was done. Abdomen was opened by midline laparotomy incision. Uterus was found to be normal. There was a laceration of 8cm in the posterior fornix extending to the cervix on the left side with profuse bleeding. An attempt to obtain hemostasis failed and proceeded to Total abdominal hysterectomy. Omentum, hollow viscus, and all other intra abdominal organs were normal. Abdomen was closed in layers after complete hemostasis. Episiotomy wound sutured. Post operative period was uneventful.

**Summary:**
This is a case of secondary spontaneous complete colporrhexis following failure of domiciliary delivery proceeded to Total abdominal hysterectomy.

**Discussion:**
Colporrhexis is the rupture of the vaginal vault. It occurs most commonly following extension of a laceration from the lower uterine segment or cervix. Primary colporrhexis is a rare complication of labour. Hegenberger in 1875 first coined ‘Colporrhexis’ and described 40 cases from the literature. Colporrhexis may be primary or secondary, spontaneous or traumatic, complete or incomplete. Vaginal vault tear not associated with cervical or uterine extension is primary. Traumatic instrumental delivery, previous vaginal injury, precipitate labour, oxytocics, misdirection of uterine axis due to pendulous abdomen, ventroflexion of uterus, evacuation of full rectum after enema and prolapse are the causes of primary colporrhexis. Secondary colporrhexis cannot be differentiated from a rupture that has originated in the uterus and extended to involve vagina. Incomplete colporrhexis includes rupture of vaginal epithelium and muscularis. Complete involves overlying peritoneum and is usually associated with high parity but also reported in primi. Complete type is 5 times as common as the incomplete type.

**References:**


