Coitus per Urethram and the Rigid Hymen

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COITUS PER URETHRAM is extremely rare; merely 13 cases have been reported in the world literature.1-10 This oddity has been observed mostly in women with either a rigid hymen or vaginal atresia. P. H. Gebhard (personal communication, April, 1965) at the Institute for Sex Research of Indiana University, although not encountering instances of coitus per urethram in women, learned of an unusual case which demonstrated the great elasticity of the human urethra. A man made an artificial hypospadias and progressively enlarged the urethra enabling insertion of another man’s penis. W. B. Pomeroy (personal communication, March, 1965) during many years of association with the Institute for Sex Research, encountered examples of urethral masturbation but none of coitus per urethram.

In addition to its rarity, this case report was prompted by the length of time the coitus per urethram was practiced, without any side effects other than urinary incontinence.

Report of a Case

A 32-year-old nullipara, who had been married for ten years, was admitted with the chief complaint of urinary incontinence. She had difficulty maintaining a steady stream during voiding and stated that when she stood up after micturition, 2 to 3 oz of urine gushed out. She also had some dyspareunia and prolonged menstrual bleeding.

Physical examination revealed a normally developed attractive woman. Pelvic examination showed a tight vaginal introitus, due to an annular fibrotic hymen, which admitted an index finger with difficulty. The urethra was widely gaping and admitted an index finger with ease; in fact, the urethra readily admitted two fingers or a large rectal dilator (Fig 1, 2).

Enlargement of the vaginal opening, hymenotomy, and plication of the urethra were done. The Foley catheter was removed on the fifth day, and the patient voided normally. A 12-month follow-up examination revealed that the urinary problem was corrected. The patient stated that sexual intercourse per vaginum has been satisfactorily established.

Comment

The mere presence of a fibrotic hymen does not necessarily lead to coitus per urethram. This sexual deviation probably results from a combination of associated factors including vaginal aplasia or a fibrotic hymen, malposition and poor tone of the urethra, and unexplained psychic factors. This patient’s hymen resisted penetration during an active sexual life. Her prominent external urethral meatus may have been the initiating factor which led to the gradual but constant dilatation of a weak urethral structure, permitting the continuous sexual practice over a period of many years without

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JAMA, Nov 22, 1965 • Vol 194, No 8
apparent physical or psychic trauma. The absence of complete urinary incontinence in such a widely gaping urethra, as well as the lack of urethral and bladder infection in spite of repeated urethral and bladder assaults, is puzzling.

To determine the length of time abnormal coitus was practiced in the presence of a fibrotic hymen without leading to coitus per urethram, we reviewed the records of patients admitted to the Graduate Hospital of the University of Pennsylvania during the past 20 years with a diagnosis of fibrotic hymen; 31 such cases were found. Seven patients waited two to four weeks before seeking medical advice, five waited four to six months, nine waited 1 to 4 years, and one waited 18 years. These 22 patients were treated by incising longitudinally and suturing transversely to vagina mucosa as well as the underlying superficial perineal muscles. All patients made an uneventful recovery. The remaining nine patients were admitted to the emergency room for suturing of a lacerated hymen following sexual intercourse.

Summary

Thirteen instances of coitus per urethram were found in a review of the world literature. The duration of urethral intercourse was from 1 to 13 years. Attributable causes were rigid hymen (two patients) and vaginal atresia (ten patients). Two of the patients had urinary incontinence as the only symptom; two had urinary incontinence, dyspareunia, and abnormal uterine bleeding; and one had dyspareunia as the only complaint. None of the patients sought medical advice because of urinary-tract infection.

The primary concern of the patient reported here who had had coitus per urethram for ten years, was urinary incontinence after voiding and abnormal vaginal bleeding; dyspareunia was only a minor complaint. Cure was obtained by urethrovaginal plastic surgery.

References


Hepatoma Metastasizing to the Esophagus

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CARCINOMA metastasizing to the esophagus is rare. Gross and Freedman" cited a review of 1,000 autopsies performed on patients with cancer in which only 11 esophageal metastases were found. They added one case with primary site in the prostate and refer to three other cases, found in the literature, with distant primaries. Toreson" found 26 esophageal metastases in 599 consecutive autopsies of patients with cancer. Metastases from distant primary sites were infrequent, occurring in only two of the 11 cases in the series cited by Gross and Freedman, in their own case, and in the three cases they found in the literature, and in only seven of the 26 cases of Toreson. The majority of the cases of esophageal involvement by tumor were from adjacent organs such as stomach, larynx, trachea, or bronchus, presumably by direct extension. Additional reports of malignant neoplasms metastasizing to the esophagus were made by Sasson"; by Maissa and Corbella"—both single case reports—and by Chene et al, a report of eight cases. A variety of distant primary neoplasms were mentioned in the series quoted, no one site being a source with significantly greater frequency than the others.

We recently studied a patient with an esophageal tumor which proved to be a metastasis from a hepatoma arising in a cirrhotic liver. Review of the literature failed to reveal a similar case. Of further interest is the apparent route of metastatic spread.

Report of a Case

A 74-year-old white man was admitted to the Maimonides Hospital on Aug 27, 1963, because of anorexia, without dysphagia, and a 60-lb (27.3 kg) weight loss over a four-month interval. An esophagogram showed an intraluminal polypoid lesion of the distal esophagus, proximal to the diaphragmatic hiatus. The barium clearly outlined the interstices between the polypoid projections. The margins of the lesion were sharp, and there was no significant compromise of the esophageal lumen (Fig 1).

Physical examination revealed a liver edge palpable two fingerbreadths below the right costal margin and a firm, nontender, 8 x 10-cm mass in the midepigastrium, continuous with the left lobe of the liver. The only abnormal laboratory findings were an alkaline phosphatase of 15.6 King-Armstrong units and a sulfobromophthalein retention of 30%.

Esophageal biopsy revealed hepatoma metastasizing to esophageal mucosa with secondary mucosal ulceration. Liver biopsies at two sites revealed an unsuspected portal cirrhosis but no tumor.

During the patient's one month of hospitalization, no specific therapy was given. He was readmitted subsequently for ten days for bronchopneumonia, which responded to penicillin therapy.

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