

Labial adhesion in girls seldom needs treatment.

Don't tamper with nature

In this issue of the Journal of the Norwegian Medical Association, S. Knudtzon and colleagues publish an informative article about the diagnosis and treatment of labial adhesion (1). Although this condition is fairly common, it is not especially well known among parents and health personnel, perhaps because a majority of girls have no symptoms (1–6). In some studies, the incidence is as high as 20–40%, and one author asks whether labial adhesion should be viewed as a normal finding in prepubertal girls (4). The condition is considered to be acquired, as it does not exist in the first three months of life (6). Since it does not exist after puberty either (2–6), it is assumed that the fusion is connected to the naturally low oestrogen level in the years between the neonatal period and fertile age (2,4–6).

The diagnosis is made simply by means of inspection. The condition is distinguished from vaginal agenesis, absence of a vagina and imperforate hymen in that in those cases the vulva and labia minora appear normal and the urethral meatus is visible (5). The labia minora may be quite firmly fused at the time of diagnosis. Since the natural course of the condition is spontaneous normalisation before puberty (1–6), there will of course also be girls with very low-grade adhesions. At the initial medical consultation, an attempt to pull the labia apart without anaesthetic might be tempting. In my experience, this is not advisable. Children's perception of pain is individual, and just being held will be a frightening experience for many. On such occasions, there should be a low threshold to using local anaesthetic or even general anaesthesia.

In their study, our colleagues at St. Olavs Hospital have shown that the results of topical application of oestrogen or glucocorticoid cream and surgical treatment are both poor – at the end of the treatment, the fusion had opened in only a little more than half of the cases (1). However, the result is consistent with the literature (2, 6). Given the natural course of the condition, it is a weakness of this study that only eight out of 105 girls were observed without treatment, and only four of them were monitored until normalisation. The authors nevertheless conclude: «The condition resolves spontaneously in all, at puberty if not before». The patients at St. Olavs Hospital have not been followed for long enough to confirm this assertion, although it is firmly grounded in the literature (2–6). It is further concluded that observation alone ought to be the first choice of treatment for asymptomatic girls. This recommendation also appears to enjoy a broad consensus (2–6). In case of any concomitant complaints, such as urinary tract infection, urethritis or vulvovaginitis, on the other hand, it is common to recommend that the fusions be opened (2–4, 6). Such concomitant complaints may, however, be unrelated to the adhesion. In the well-reputed Hôpital Necker-Enfant malades, where approximately 40 new cases of this condition are observed each year, the adhesions are not opened, not even in those who are treated for the diseases mentioned above. The labia are only opened when there is a need for access to the urethral meatus (e.g. for cystography) or in cases of lichen sclerosus (5).

When an adhesion is diagnosed, the most important issue is to assure the parents that there is no reason for concern and then provide thorough information on the natural progress of this condition while emphasising the importance of good perineal hygiene. In my opinion, any further follow-ups and check-ups of asymptomatic girls (with or without adhesion) are unnecessary. Treatment might be relevant for those who have concomitant symptoms. If so, information on the treatment alternatives must include reference to frequent recurrences after drug-based as well as surgical treatment (2–4). One author reports recurrence in as many as 40% (6). Moreover, it might be awkward to prescribe a treatment that requires little girls to be rubbed with cream in the genital area twice daily for up to eight weeks (1). Many parents might feel uncomfortable with this task. All the above, and because treatment might be uncomfortable and entail adverse effects (1), argues in favour of recommending observation as the only intervention. Although I have a liking for the treatment principles applied at the Hôpital Necker (5), I have no problem in accepting the fact that some parents view this matter differently. Their wish to open the adhesion, surgically or by means of drugs, should then be complied with – after all, this is not a major issue.

To sum up, Knudtzon and collaborators have provided an important contribution to inform all those who work with small children about a common condition that affects the genitals of girls and that occasionally requires treatment. As a rule, however, the best intervention is to wait for nature to put things right by itself.

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