

**Congenital birth defects
can include the absence of
a vagina—and it occurs in
one out of every four to
five thousand female
babies. Devastating, yes
...but not a hopeless
situation these days.**

By Noreen Nash Siegel

□ Sometimes nature slips up. Sometimes in an embryo, a faulty gene or chromosome lurks or cells fail to divide and proliferate according to design. Considering the complexity of human anatomy, it's not surprising that occasionally during the embryonic stage, a few of those billions of cells fail to develop normally. Cleft palate, harelip, and clubfoot are a few of the congenital abnormalities known to most of us, but there is one few have heard of, one that is rarely spoken of. Yet today, there are at least twenty thousand to thirty thousand women in the United States alone who were born with this abnormality: the absence of a vagina. According to the late James Ingram, M.D., who was a professor of obstetrics and gynecology at the University of South Florida, "There are many women born without a normal vagina who are unaware that a remedy is available."

Marie was one such woman. At seventeen, she had never been to a doctor until she walked into the nearest teaching hospital. Her parents, poor and uneducated, rarely sought medical attention; to them, it was a luxury. But now, in desperation, Marie had come seeking help. Although married for three months, she was still a virgin. Despite repeated attempts, her ardent young husband had been unable to penetrate her hymen. Finally, in frustration, he had resorted to anal sex, much to Marie's displeasure.

Apprehensive and anxious, Marie took her seat opposite the young medical student assigned to her. It was his first day on the gynecology service, and he, too, was uneasy. A short history revealed that Marie had experienced monthly cramps since the age of twelve. She had never menstruated but had not thought it cause for concern, having heard of other girls who began menstruating at a late age. The student assumed Marie had an unperforated cartilaginous hymen, which would prohibit blood and vaginal fluids from escaping. In such cases, a simple medical

procedure can be performed to break the hymen.

The nurse prepared Marie, draping her and putting her feet in the stirrups. Then the medical student began his examination. The girl had normal breasts, bodily proportions, and hair growth. The external genitalia appeared perfectly normal—but there was no hymen. Where the vaginal canal should have been, there was nothing. In disbelief, the student probed the perineum but could find no trace of a vagina. He summoned his attending physician, who, after examining Marie thoroughly, concluded that she had what is known as congenital absence of the vagina (CAV). Nature had played a rotten trick on Marie. She had no vagina, no cervix, and no uterus—just rudimentary, functionless cords. Her ovaries and oviducts, however, appeared normal. Marie had been born with a condition so rare, the doctor had seen it only once before.

On hearing the diagnosis, Marie became hysterical. It must be a mistake! And it was a mistake . . . nature's, not the doctor's. Early in the embryonic stage, Marie's vagina and uterus had failed to develop properly. A myriad of emotions—shock, confusion, disbelief, fear—swamped her. Every woman had a vagina, but she was different; she wasn't really a woman, she was a freak! Would she ever be able to face her husband? The doctor quieted her. . . . Surgery could be performed to create an artificial vagina. *Surgery, artificial*—these words stunned her. She had never had an operation, she was frightened of the anesthetic, of the knife, of maybe dying, and who would want an artificial vagina anyway? Not only that, she had no money. How could she go through with it? How could she afford it? It was hopeless, useless. She would be better off dead.

The doctor saw that Marie was suicidal. He arranged for her to have counseling immediately. Her husband, eager for her to have the operation, intervened. He loved her, he would stand by her, she must have the operation. They would find a way to pay for it.

Arrangements were made, and two months later, Marie underwent vaginoplasty to correct the abnormality. An incision was made between her urethra and rectum, then skin taken from the bikini area of her buttocks was wrapped around a vaginal mold—a condom tightly packed with foam rubber—which was then held in place by suturing the labia majora together. Fourteen days later, the mold was removed. From then on, twice a day for fifteen minutes at a time, Marie had to use a lubricated glass dilator. The doctor warned her that if she did not do this assiduously each day, the vaginal opening would close and the operation would be for naught. (This had been the fate of the only other CAV patient the doctor had operated on.) Six weeks after surgery, the doctor examined Marie and found the neovagina soft and resilient. He said that in three months, the vaginal walls

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VAGINA [continued from 74]

would be thick and strong enough to permit coitus; the new skin would soon become like normal vaginal mucous membrane.

At first, Marie was reluctant to engage in sex. She was certain she was frigid, but the doctor assured her that she could function like any other woman and urged her not to become discouraged. Masters and Johnson had done extensive research on women operated on for CAV and had found that almost all of them were able to have orgasms. Both they and their partners reported satisfactory intercourse.

Laura's story was somewhat different. Born to an upper-middle-class family, her mother was bright, aware, well-educated. Soon after Laura was born, her mother noticed that where the vagina should be, there was only a dimple. Knowing enough about female anatomy to suspect something was wrong, she took her daughter to a pediatrician, who confirmed that Laura had been born with no vaginal opening. He referred her to an expert, who said nothing could be done at that time but asked her to bring Laura back after she reached puberty. Only about half of CAV cases are diagnosed before age twelve, he said, and surgery performed much before the age of sixteen or eighteen is doomed to failure.

Laura's mother doted on her, gave her dancing lessons, singing lessons, acting lessons. She pampered her, loved her, protected her, and when she was twelve, took her to a psychiatrist who explained why she would never menstruate as other girls did. Because of her mother's attitude and the psychiatric conditioning, Laura accepted her condition; at the age of fifteen, she underwent surgery with no apparent trauma. From then on, she had to use the vaginal dilator to keep her new vagina from closing up.

At an early age, Laura became aware of the pleasurable parts of her body and began to experience orgasms. She had her first affair at sixteen. (When the boy offered to wear a condom, she told him it wasn't necessary, she was on the Pill.) In high school and college, she had several affairs, but none were serious. She never told anyone about her operation, but at twenty-two, she fell in love. Despite fears that she might lose the man, Laura decided to be honest with him. He swore it made no difference, that he had never made love to a more responsive or sensual woman. For two years, they lived together happily, but when she brought up the subject of marriage, he told her that despite being in love with her, he could not marry her, for he wanted children of his own. Laura was heartbroken, but knowing marriage was out of the question, she decided to move out, never to see him again.

She pursued her career seriously and

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with her looks, talent, and determination, soon achieved success. Today, she is happily married—a successful, very well-known woman—and is experiencing the joys of motherhood with a recently adopted baby. Like most women with CAV, she has no uterus (less than 5 percent do). She does, however, have normal, functioning ovaries. Using in vitro fertilization, an egg taken from her ovaries could be placed in a petri dish and fertilized with sperm from her husband. The fertilized egg could then be implanted in a donor uterus—a woman who would carry the fetus. The knowledge that one day she and her husband might have a baby of their own is an exciting possibility.

A passage in *Lives of Fair and Gallant Ladies*, by DeBrantome, a sixteenth-century writer and gossip, refers to a historic case of CAV. He writes, "I knew a lady of very high rank, aged seventy, who had refused to marry, but this was no virgin. At least she had been to bed with men, but it was stated she was unfit to be a wife because she was not made as other women, having only the smaller opening through which she passed water. On this account, she was not only excused but commended for not marrying. Certainly, she had some door to open to men, for she gave good entertainment both to them and to herself. This lady was none other than the Queen of England, Elizabeth I."

Is it possible that the great sixteenth-century Queen was born without a vagina? One authority on CAV believes it and cites other sources. Ben Jonson, the famous playwright, said, "Elizabeth had a membrane on her that made her incapable of man, though for her delight, she tried many." The Queen's physician enraged Parliament when he advised her not to marry; she herself said she was of barren stock. It was rumored that she had no monthly period and suffered emotional stress because of abnormal stoppage of menses. After her death, rumors of her malformation proliferated. They could not be silenced when, at her request, no autopsy was performed—something that, in those days, was not only customary for every sovereign but practically mandatory. Was Elizabeth I born with no vaginal opening? One can only conjecture—there is no proof—but if so, this slip of nature changed the history of England and Europe!

Congenital absence of the vagina is rare—but not as rare as one might imagine. It occurs in one out of every four thousand to five thousand female births and has been reported in nearly every country of the world, in all races and social strata. The Greek physician Hippocrates alluded to it. It wasn't until 1572 that an Italian anatomist gave a detailed

description of the anomaly. The first successful attempt to correct it came early in the nineteenth century but ended tragically when the patient died of sepsis, prompting the surgeon to advise against anyone else's attempting it.

With the advent of better surgical techniques in the twentieth century, the operation was attempted once more. In the 1930s, surgeons popularized a method of creating a neovagina by using inlay split-thickness skin grafting, followed by regular use of vaginal dilators to prevent closure. Although the procedure has been highly successful, there is one underlying problem—contracture. Nature, recognizing the neovagina as foreign, wants to close it down. A patient must keep it open with frequent coitus or by using vaginal dilators regularly.

Dr. Ingram was aware of the disadvantages of surgery when he started out in the field. (Besides contracture, some patients also developed a fistula between their rectum and urethra.) Wasn't there some way to create a vagina non-surgically? Dr. Ingram had heard of a woman who actually created a functional vagina through coitus alone—possible because the flesh between rectum and urethra in CAV women is extremely soft, tenuous, and pliable. He thought it would be possible to create a neovagina with pressure alone, and he began experimenting. He had the patient sit on a bicycle-seat stool with a lucite vaginal dilator between her labia minora for fifteen to thirty minutes at a time, for a minimum of two hours a day. Gradually, the size of the dilators was increased. It involved time, patience, maturity, and motivation, but it worked.

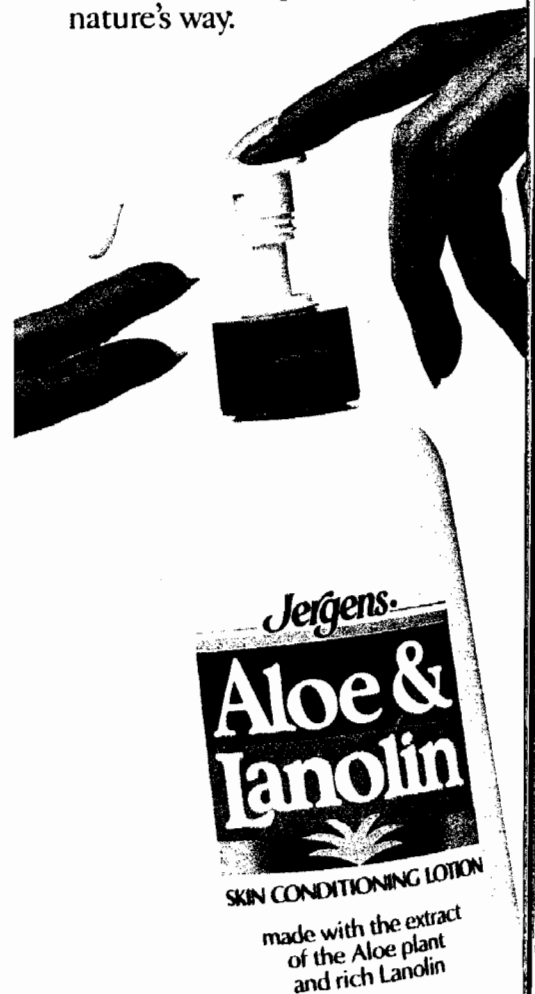
It took from five and a half to eleven months to create a neovagina, but the procedure eliminated the need for surgery, and—more important—there was no contracture afterward. The neovagina remained open, even in patients who weren't sexually active. (Because passive dilation is a long and tedious procedure, Dr. Ingram believed it important to use a successfully treated patient as a model for motivation and to have significant support—both clinical and emotional—from a nurse.) John Rock of Johns Hopkins University says this new method is now successfully replacing surgery in about 80 percent of CAV cases.

Are these women orgasmic? "Very," said the late Dr. Ingram. "As a group, they appear to be much more sexually responsive than women who do not have to create their own vaginas."

Once, congenital absence of the vagina was a devastating diagnosis for any young girl. There was no hope; there was no remedy. But today, these women can lead satisfying, sexually active lives . . . and with in vitro fertilization, may even have their own offspring. ☐

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