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CASE REPORT

Thirteen Foreign Bodies Retained in the Vagina for More Than 20 Years in a Postmenopausal Woman: Case Report

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Abstract: Vaginal foreign bodies (VFBs) can affect women of all ages, but they are most frequently observed in the pediatric population. Such cases are relatively uncommon in women of reproductive age and postmenopausal women, and the long-term retention of foreign bodies in adults is particularly rare. We report a case of a 53-year-old postmenopausal woman with a history of bipolar disorder and autism spectrum disorder who presented with persistent vaginal bleeding, discharge, and foul odor for one year. She admitted to inserting various objects into her vagina annually since her early 30s. Imaging (ultrasound and CT) revealed multiple hyperechoic structures within the vaginal canal. Hysteroscopic examination demonstrated extensive inflammatory hyperplasia and polypoid lesions. A total of 13 foreign bodies, including porcelain bottles, a button, medicine bottles, and candy wrappers, were successfully retrieved. Postoperative histopathology confirmed benign inflammatory changes, ruling out malignancy. The patient recovered uneventfully. This case highlights the diagnostic challenges and management of long-term retained VFBs in postmenopausal women with psychiatric comorbidities. It underscores the need for a high index of suspicion in such patients presenting with non-specific gynecological symptoms to prevent severe complications.

Keywords: foreign bodies, vagina, postmenopause, hysteroscopy, mental disorders, case report

Introduction

Vaginal foreign bodies (VFBs) are an infrequent clinical entity in gynecology, predominantly observed in the pediatric population due to self-insertion.[1] Their occurrence in reproductive-aged and postmenopausal women is considerably rarer. A notable exception is among individuals with cognitive impairment, psychiatric disorders, or dementia, where the incidence of VFB insertion is significantly higher.[2] Prolonged retention of VFBs can lead to a cascade of serious complications, including chronic pelvic pain, persistent vaginal discharge/bleeding, infection, fistula formation (eg, vesicovaginal or rectovaginal), and even malignant transformation secondary to chronic inflammation.[3,4] We report an extreme case of 13 VFBs retained for over two decades in a postmenopausal woman with bipolar disorder, emphasizing the diagnostic challenges and the importance of considering VFBs in similar high-risk populations.

Case Presentation

A 53-year-old woman was admitted to Suzhou Municipal Hospital (our institution) on October 26, 2025, with complaints of intermittent vaginal bleeding, discharge, and odor persisting for over one year. She had pharmacologically induced menarche at age 18, after which her menstrual cycles were regular until menopause at 51. The patient is unmarried, and her family denied any history of sexual activity. Her family reported that she had a history of repeatedly inserting objects

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into her vagina since her early 30s. Approximately one year prior to presentation, she developed recurrent episodes of unexplained, scant vaginal bleeding accompanied by discharge and odor, each episode lasting approximately three days before resolving spontaneously.

Past medical history includes congenital dysplasia, congenital hip dislocation, and bronchial asthma with no reported episodes in the past 20 years. She has a more than 10-year history of hypertension, which is currently well controlled. The patient is alert, fully oriented, and communicates coherently. Her mother is deceased; she is an only child and is accompanied by her father.

One month prior to admission to our hospital, she presented to another facility with abdominal pain. An abdominopelvic CT scan performed at that time revealed a uterine malformation with a suspected intrauterine foreign body (Figure 1). Hospital admission for further evaluation was recommended. However, upon admission, the family adamantly refused vaginal examination under anesthesia or any surgical intervention and requested discharge. The patient subsequently presented to our outpatient clinic, where hospitalization was again advised.

The patient was admitted to our hospital on October 26, 2025. Post-admission ultrasound evaluation of the uterus and adnexa: the uterine body dimensions approximately 32×24×27 mm, with homogeneous echotexture and a thin, linear endometrial lining consistent with postmenopausal status. The cervix was enlarged, measuring approximately 65×33 mm, and demonstrated heterogeneous echogenicity with multiple linear, irregular hyperechoic foci. Color Doppler flow imaging (CDFI) showed no significant abnormal vascularity. Ultrasound findings: Postmenopausal uterus, enlarged cervix with abnormal echotexture, and a suspected foreign body. Based on the patient's history, ancillary test results, and physical examination findings, the following admission diagnoses were established: 1. Abnormal uterine bleeding; 2. Vaginal foreign body; 3. Hypertension.

Upon admission, the patient's complete blood count, coagulation profile, tumour biomarkers, and inflammatory biomarkers were within normal limits. Given the prolonged retention of intra-vaginal foreign bodies and clinical signs of local infection—including purulent discharge and foul odor—which pose an increased risk for surgical site infection, empiric intravenous antibiotic therapy with Cefonicid sodium 1 g daily was initiated for four days. Surgical intervention was subsequently planned. Throughout hospitalization, the patient remained psychiatrically stable and did not require psychological counseling or psychiatric consultation.

On October 31, 2025, the patient underwent hysteroscopy under ultrasound guidance. Under ultrasound guidance, insertion of the hysteroscope identified multiple white, hard foreign bodies within the vaginal canal (Figure 2A). The large number of objects obscured complete visualization, necessitating their sequential removal. A total of 13 vaginal foreign bodies were extracted using oval forceps to grasp narrow portions of the objects. Upon reinsertion of the hysteroscope, no significant residual foreign bodies were observed. Extensive inflammatory and firm polypoid neoplasms were found in the vaginal wall (Figure 2B), along with impressions consistent with the prior presence of foreign bodies (Figure 2C). The vaginal neoplasm tissue was fixed-point biopsy, and the tissue specimens were sent for pathological examination. The cervix appeared irregular in morphology, which hindered clear endoscopic visualization. The internal cervical os was closed.

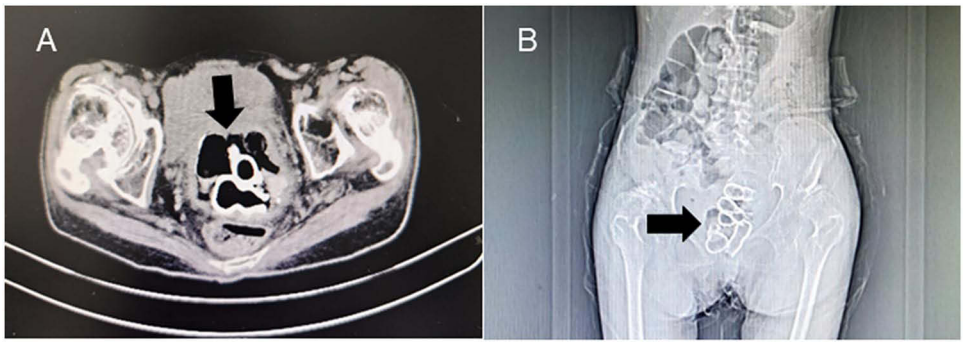

Figure 1 Preoperative abdominopelvic CT scan. (**A** and **B**) Irregular hyperdense lesion (arrows) within the pelvic cavity, suspicious for a foreign body.

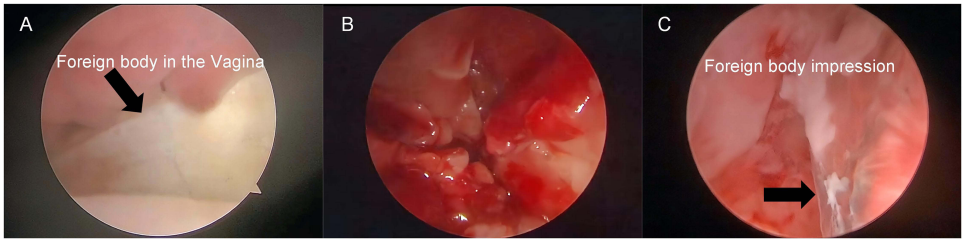

Figure 2 Hysteroscopic views of the vagina. (**A**) White, hard foreign body visualized in the lower vagina. (**B**) Extensive inflammatory hyperplasia manifesting as firm, polypoid lesions on the mid-vaginal wall. (**C**) Indentations and tissue impressions on the vaginal wall noted immediately after foreign body removal.

To minimize infection risk, intrauterine exploration was not performed. Therefore, the procedure consisted of hysteroscopic removal of vaginal foreign bodies, non-incisional extraction of cervical foreign bodies, and excision of exophytic inflammatory vaginal lesions. Intraoperative exploration revealed 13 foreign objects of varying sizes (Figure 3). Postoperatively, the patient's vital signs remained stable, and she was transferred to the ward. A plain pelvic X-ray confirmed the absence of residual foreign bodies (Figure 4). She was discharged the following day, afebrile, with

Figure 3 The thirteen foreign bodies retrieved during the procedure. A total of 13 objects of various sizes and materials were removed from top to bottom, from left to right including, 2 plastic candy packaging bags, 1 green plastic bottle, 2 yellow brown plastic bottles, 1 hard plastic lid, 1 glass, rectangular prism-shaped object, 1 plastic button, and 5 white porcelain bottles.

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Figure 4 Postoperative plain pelvic radiograph confirming the complete removal of all radiopaque foreign bodies, with no residual opacities visible. The meaning of "L" is the left side of the human body.

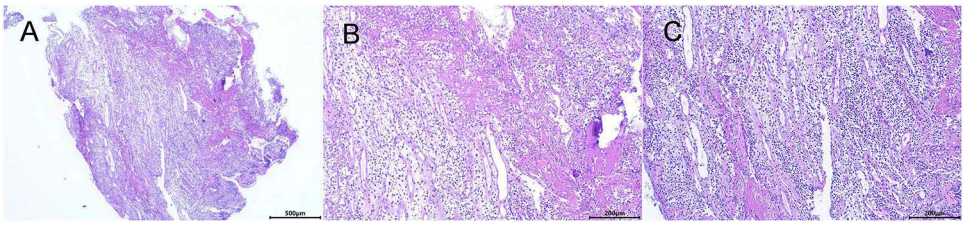

Figure 5 Photomicrograph of the resected vaginal lesion (Hematoxylin and eosin stain, original magnification x200). The section shows acute and chronic inflammation with squamous epithelial hyperplasia, focal inflammatory necrosis, and granulation tissue formation. No evidence of malignancy was found. (**A**) Postoperative routine pathology, in which acute and chronic inflammation with squamous epithelial hyperplasia, focal inflammatory necrosis, and granulation tissue formation can be seen. (**B**) Postoperative routine pathology, in which acute and chronic inflammation with squamous epithelial hyperplasia, focal inflammatory necrosis, and granulation tissue formation can be seen. (**C**) Postoperative routine pathology, in which acute and chronic inflammation with squamous epithelial hyperplasia, focal inflammatory necrosis, and granulation tissue formation can be seen. The 500um for image (**A**) and the 200um for images (**B** and **C**) are scale bars. This means that the length shown on the images represents 500um or 200um in reality.

a normal complete blood count and no complaints of discomfort. Postoperative pathology showed: (resected vaginal lesion) acute and chronic inflammation with squamous epithelial hyperplasia, focal inflammatory necrosis, and granulation tissue (Figure 5).

Discussion

VFBs are predominantly observed in the pediatric population, often resulting from accidental insertion of objects into the vagina.[1] In adults, VFBs are far less common and typically involve items such as tampons, pessaries, or sexual aids. Their presence may also be linked to factors like violence, sexual assault, or specific sexual practices, particularly in women with cognitive impairment (eg, dementia).[5] Clinical manifestations are highly variable and depend on the foreign body's size, nature, and duration of retention.[6] In sexually inactive women, VFBs may remain entirely asymptomatic, which can explain their prolonged, undetected presence. When symptoms do occur, common presentations include recurrent vulvovaginitis, urinary tract infections, vaginal bleeding, purulent discharge, vaginal ulcers, perforation, and vesicovaginal or rectovaginal fistulas.[7] Persistent inflammatory reactions triggered by foreign bodies can stimulate papillary hyperplasia (granulation tissue formation) in the vaginal mucosa, leading to vaginal adhesions, stenosis, or even complete obstruction. Such slowly progressive pathological changes allow foreign bodies to remain in the body for years with minimal or no symptoms.[8] Furthermore, prolonged retention of VFBs can compromise the local immune defenses of the lower genital tract, predisposing patients to ascending infections such as endometritis, salpingitis, pelvic peritonitis, and potentially, infertility. Severe cases may even result in systemic infection and sepsis.[9]

Although multiple cases of postmenopausal women or vaginal foreign bodies persisting for decades have been documented, the presence of 13 objects in this patient is exceptionally rare. The patient has a known history of bipolar disorder and autism spectrum disorder. The precise motive for the repeated self-insertion of these objects over such an extended period remains unclear, and the reliability of her historical account is difficult to verify.The absence of significant symptoms following insertion allowed the objects to remain undetected for over two decades. Two years after menopause, she developed vaginal odor, intermittent bleeding, and discharge. This clinical presentation was likely a consequence of chronic mechanical friction and irritation from the retained foreign bodies, which induced the formation of inflammatory granulation tissue and polyps in the vaginal wall, ultimately leading to secondary infection and bleeding. This case underscores that while VFBs are a rare cause of gynecological symptoms in postmenopausal women, they must be considered in the differential diagnosis, particularly for patients with underlying psychiatric disorders presenting with unexplained vaginal bleeding or discharge. A failure to do so may lead to a missed diagnosis and delayed treatment.[2]

Although cases of vaginal foreign bodies (VFBs) retained for decades in postmenopausal women have been documented, the presence of 13 distinct objects in a single patient is exceptionally rare. The potential sequelae of such long-term retention are severe and well-documented, including vesicovaginal fistula, rectovaginal fistula, and even malignant transformation.[10] For instance, Mengistu et al described a patient in whom a bottle cap retained in the vagina for two years ultimately presented with urinary leakage, and examination confirmed a vesicovaginal fistula.[11] In another striking case, a 7-year-old girl presented with malodorous vaginal discharge due to a 22 cm long, 2 cm diameter cassava stick that had been retained for six months, causing vaginal perforation into the pouch of Douglas.[12] Furthermore, Osman et al reported a case of uterine sarcoma potentially associated with prolonged VFB retention. A 4 cm × 2.5 cm calcified foreign body, presumed to be retained surgical gauze from a catheterization procedure nine years earlier, was found in the vaginal vault. The authors hypothesized that chronic inflammation from the long-standing irritant may have triggered the sustained release of pro-inflammatory and genotoxic mediators from macrophages in the connective tissue, ultimately contributing to carcinogenesis.[13] This underscores the critical importance of a meticulous intraoperative assessment for fistulous tracts in all cases of long-standing VFBs, with a view to prompt repair. Concurrently, a high index of suspicion for malignant change is essential to facilitate early diagnosis and intervention.

While most adults would voluntarily seek removal of a foreign body, this is often not the case in patients with underlying psychiatric disorders. Consequently, misdiagnosis or delayed diagnosis is common in this population. Such patients often present with non-specific physical complaints, and the VFB is frequently discovered incidentally during the workup for these symptoms.[14] Therefore, a detailed medical history, combined with a comprehensive gynecological examination, is paramount for establishing the diagnosis. A speculum and bimanual examination often allows for direct visualization or palpation of the foreign body. If vaginal examination is not feasible, a rectoabdominal examination can be a useful adjunct. In the present case, however, the patient's cognitive impairment, combined with her being unmarried and her family's denial of any sexual history, led to her refusal of a vaginal examination. This significantly complicated both the preoperative assessment and surgical planning. Secondly, imaging plays a pivotal role in localizing VFBs and assessing the extent of any associated inflammatory process.[7] In this case, the VFB was first suspected on an abdominopelvic CT scan performed for lower abdominal pain. Transvaginal ultrasound is generally considered the modality of choice for detecting VFBs.[15] Supporting this, a large retrospective study by Yang et al involving 249 patients reported a sensitivity of 81%, a specificity of 53%, and a 100% detection rate for foreign bodies ≥5 mm in diameter.[16] Pelvic plain radiography is useful for detecting radiopaque objects but has limited value for radiolucent ones.[17] Pelvic MRI, with its superior soft tissue resolution, is the optimal modality for evaluating associated complications such as fistulae, as it can clearly delineate the extent and anatomical relationships of the defect. However, it is not suitable for assessing metallic foreign bodies.[18]

The cornerstone of managing vaginal foreign bodies is their prompt and complete removal, with minimal iatrogenic injury.[19] Hysteroscopy offers a safe, effective, and minimally invasive approach for removal. It provides excellent visualization of the vaginal vault, which not only minimizes the risk of missing residual fragments but also allows for precise, directed extraction, thereby reducing the likelihood of injury to adjacent structures like the bladder and rectum. This makes it particularly suitable for cases with suspected vaginal adhesions or stenosis secondary to prolonged VFB retention. In the present case, given the >20-year retention period and the consequently obscured anatomical planes

between the foreign bodies, vaginal wall, bladder, and rectum, a hysteroscopic approach under direct vision was the preferred strategy to ensure safe and complete removal. Laparoscopic exploration may be combined when necessary to rule out perforation of the foreign body into the pelvic or abdominal cavity, allowing for timely repair.

Conclusion

This case report serves as a stark reminder that vaginal foreign bodies, while rare in postmenopausal women, can remain asymptomatic for decades, particularly in patients with underlying psychiatric or cognitive disorders who may not seek timely medical attention. This case presents the following notable characteristics: (1) An extremely long latency period between foreign body insertion and the onset of clinical symptoms; (2) The patients had mental disorders, and the family members had low cooperation; (3) The patient reported intentionally inserting the objects, potentially delaying medical attention.

The presence of multiple foreign bodies can lead to chronic inflammation, granulation tissue formation, and potentially life-altering complications such as fistulae or malignant transformation. It is imperative for gynecologists to maintain a high index of suspicion for VFBs in cognitively impaired or postmenopausal patients presenting with unexplained vaginal symptoms. Hysteroscopy offers a safe and effective modality for both diagnosis and treatment in such complex cases.

Abbreviations

CT, computed tomography internal cervical; os, Internal orifice of the uterus.

Ethical Statements

Written informed consent was obtained from the patient for publication of this case report and any accompanying images. This research had obtained the approval of the Suzhou Hospital Affiliated to Nanjing Medical University and Ethics Committee of Suzhou Hospital Affiliated to Nanjing Medical University to publish the case details and it was performed in accordance with the regulations on Scientific Research Management of Suzhou Hospital Affiliated to Nanjing Medical University and the declaration of Helsinki.

Consent to Participate

Written informed consent was obtained from the patient for publication of this case report and any accompanying images.

Author Contributions

All authors made a significant contribution to the work reported, whether in conception, study design, execution, acquisition of data, analysis and interpretation; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

The authors report no conflicts of interest in this work.

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