A Rare general surgical emergency : small sowel evisceration from vaginal cuff six years after hysterectomy

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To the Editor,

Vaginal evisceration (VE) is herniation of abdominal contents through a defect in vaginal wall. It is rare and often misdiagnoses when no bowel loops are visible. Prompt diagnosis is necessary to prevent mortality and morbidity due to bowel ischemia and necrosis. We present a patient who applied with severe abdominal pain and underwent surgery because of VE.

Case Report

A 80-year-old woman applied to the emergency room with severe abdominal pain. Abdominal tenderness was detected and small bowel loops were observed (Figure 1). Eviscerated bowel loops were wholly edematous. Nor necrosis neither perforation were seen. Patient had a history of total abdominal hysterectomy+bilateral salpingo-oopherectomy six years ago due to benign adnexal mass. Physical examination was typical for VE. Bowel loops were washed with warm salin and tried to detorsion. Although they could not be detorsioned, she was taken into operation urgently after acception of informed consent. She was prepared on trendelenburg position. Laparatomy with median inferior incision was performed. Tortion and strangulation of 120 centimeters of ileum and mesentery from vaginal cuff were observed. Small bowel loops and mesentery were detorsioned and replaced into abdomen. Bowel loops covered by warm salin solution to supply better blood circulation. Gynaecology equip was invited to repair vaginal cuff. Vaginal cuff repaired with double-line suture. After repearing vaginal cuff, re-exploration was applied and perfusion of bowel loops were observed normal. After operation, patient was followed-up with parenteral ciprofloxacin and metronidazole. Post operative fifth day, patient began enteral nutrition and tolerated well. She was discharged at post operative tenth day.

Discussion

Since the first described in 1864, fewer than 100 VE cases were described in English literature (1). In spite of rarity, that emergency has 6% mortality and early diagnosis is necessary for viability of affected bowel and preventing morbidity and mortality (2). About 20% of patients undergo subsequent bowel resection (3,4).

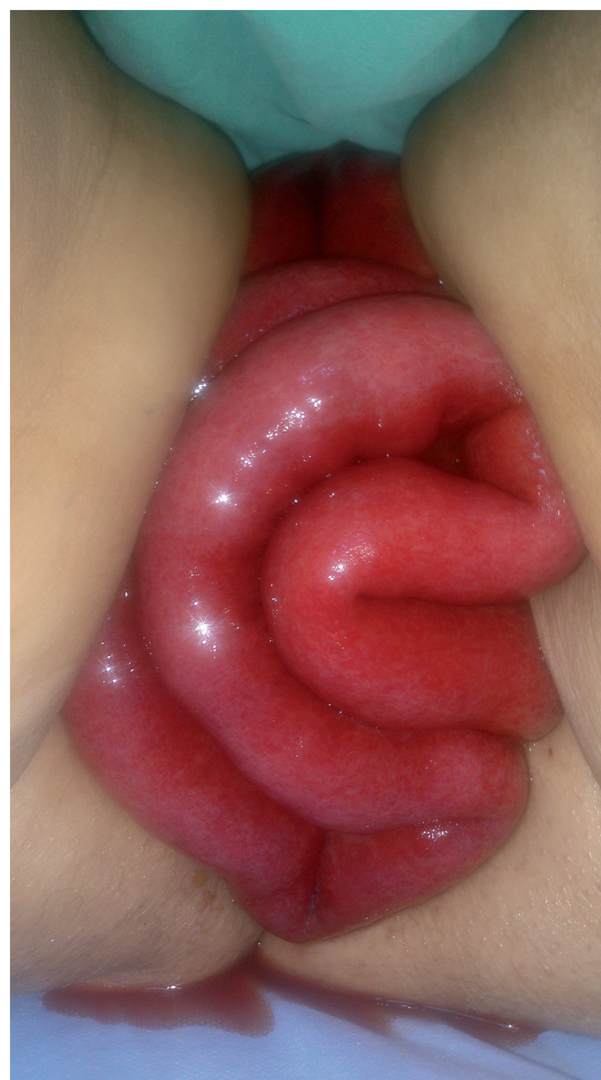

Figure 1 — Eviscerated small bowel from vaginal orifice.

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Several factors such as poor technique, postoperative infections, sexual activity before healing, radiation therapy, chemotherapy and some systemic diseases cause weakness in vaginal cuff after hysterectomy (3). History of vaginal surgery is a well-known risk factor and VE incidence is 0.032% after pelvic surgery at a mean of 27 months post-op (4). The most common surgery associated with vaginal dehiscence is vaginal hysterectomy which has reported 64% of cases in literature. Abdominal and laparoscopic hysterectomy has a rate of 21% and 13%, respectively (5). The median time for VE after pelvic surgery is 20 months (3).

Small bowel mesentery is about 15-20 centimeters and insufficient to eviscerate. It may mobilises in case of presence of longer mesentery or lengthening of small bowel mesentery secondary to laceration (6).

Most of patients apply emergency department with complaint of abdominal pain, nausea, vaginal bleeding, vaginal discharge and mass protruding from vagina. After diagnosis, intravenous fluid resuscitation, protruding bowel irrigation with warm salin should be applied. If the visible protruding bowel has pink colour and peristalsis, washing protruding bowel with salin and manuel replacement through the vaginal cuff should be tried. If manuel replacement is successful, patient may undergo transvaginal cuff repair without laparatomy. If laparatomy is inevitable, patient should be treated with broad-spectrum antibiotherapy empirically and protruding bowels shoud be covered with salin-soaked gauze until transferring to operating room. The patient should be prepared in the Trendelenburg position. Midline vertical incision is most effective incision to have best exposure, irrigate and resect necrotic bowel (3).

Despite the rarity of VE, it mostly can be diagnosed with a complete physical examination. Detailed history and complete physical examination should be performed. Computerized tomography is useful in the absence of visible bowel loops. Prompt diagnosis is important to reduce morbidity and mortality due to intestinal ischemia and necrosis.

References

1. NASR, A.O., TORMEY, S., AZİZ, M.A., LANE., B. Vaginal herniation : case report and review of the literature. *Am. J. Obstet. Gynecol*., 2005, **193** : 95-97.
2. Virtanen., H.S., Ekholm., E., Kiilholma., P.J.A. Evisceration after enterocele repair: a rare complication of vaginal surgery. *Int. Urogynecol J Pelvic Floor Dysfunct*., 1996, **7** : 344-347.
3. Ramirez, P.T., Klemer, D.P. Vaginal evisceration after hysterectomy: a literature review. *Obstet. Gynecol. Surv*., 2002, **57** : 462-467.
4. CROAK, A.J., GEBHART, J.B., KLİNGELE, C.J.,SCHROEDER, G., LEE, R.A., PODRATZ, K.C., Characteristics of patients with vaginal rupture and evisceration. *Obstet. Gynecol*., 2004, **103** : 572-576.
5. UCCELLA S., CECCARONİ M., CROMİ A., MALZONİ M., BERRETTA R. AND DE IACO P. 2012. Vaginal cuff dehiscence in a series of 12,398 hysterectomies : effect of different types of colpotomy and vaginal closure. *Am. J. Obstet. Gynecol*., 2011, **120** (3) : 516-523
6. WHEELESS C.R. JR. Evisceration. In : Nichols DH, ed. Reoperative Gynaecologic and Obstetric Surgery, 2nd edn. St Louis: Mosby Year book, Inc., 1997, 2**0**-30

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