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Case Report

Rare Case of Trans-Vaginal Evisceration of Small Bowel: Gynecologist's Nightmare

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Abstract

Gynecologists are well versed with herniation of viscera (bladder or bowel) through an intact vagina i.e cystocele or entero-rectocele. Herniation of bowel through a breach in vagina, usually vault is a nightmarish experience. We present a case of Carcinoma vaginal vault who presented with spontaneous evisceration of small bowel.

Keywords: Carcinoma; Vaginal Vault; Evisceration; Colpocleisis; Rectocele

Introduction

Spontaneous evisceration of bowel through vaginal vault is a rare but known complication post hysterectomy. About a hundred case reports have been published in this regard world over [1,2]. There are however even lesser such case reports in cases of gynecological malignancy. This clinical situation is a surgical emergency since viability of bowel is under threat. Also presence or background of malignancy poses additional challenges to management of such cases, as is evident in our case.

Case Report

77 years old postmenopausal lady presented to our outpatient clinic with complaints of mass prolapsing through vaginal vault and bleeding per vaginum of 1 hour duration. She had undergone Total Laparoscopic hysterectomy and bilateral salpingo-oophorectomy 7 years back for CIN 3 and Atypical endometrial hyperplasia. She had also undergone Cystocele repair with Sacro-spinous fixation 5 years back for vault prolapse and cystocele. She was found to have Carcinoma vaginal vault 8 months back and is on palliative chemotherapy, in view of advanced disease. On last follow up for carcinoma vault she has developed new peritoneal deposit under umbilicus, suggesting 'progressive disease'.

She gave history of constipation for past one year. On examination, she was apprehensive, afebrile, had slight tachycardia. Local examination revealed small bowel prolapsing through vault. No attempts at vaginal examination or bowel reduction were made in outpatient department. Patient was prepared for emergency exploration and surgery, and shifted to operation theatre.

General anesthesia was administered and both vaginal and laparotomy trolleys were kept ready. Exploration under anesthesia revealed about 4 loops of edematous, though viable, small bowel prolapsing through a rent in vault (Figure 1). There was large rectocele also present, however there was no anterior vaginal or vault descent. GI surgeon confirmed bowel viability and bowel was gently reduced through vault defect after a thorough warm saline wash (Figure 2). 4 cms defect in vault was identified after bowel reposition (Figure 3). There was malignant growth just 2 cms from proximal margin of vault defect. Vaginal wall was thinned out at rent site, also bowel loops were adherent near vault breach site. In view of overall poor prognosis (progressive vault malignancy) and poor vaginal wall integrity a definitive repair was not undertaken. Vault breach was reduced in size with loose interrupted Vicryl 2-0 sutures. Partial Colpocleisis was done, in view of active disease at vault (Figure 4).

Figure 1: Pre-intervention image showing prolapsed and edematous small bowel.

Figure 2: Bowel loops being reduced gently.

Figure 3: Rent at vault, edge held by stay suture.

Figure 4: After Partial colpocleisis, vaginal walls and labia apposed together.

Postoperatively patient was kept on empirical broad spectrum antibiotics for 72 hours and a close watch for any bowel leak. Patient recuperated uneventfully, and was discharged on 5th postoperative day. At 3 week follow up, all vaginal and vulval sutures had given way. This was likely due to preexistent constipation and rectocele. Patient is on laxatives presently and maintenance palliative chemotherapy.

Discussion

Hysterectomy is one of the commonest gynecological surgeries performed worldwide. Bowel herniation is a known complication post hysterectomy, though it's reported only occasionally as case reports across several journals over past century. It was first reported by McGregor in 1907 [3]. Noorbhai., *et al*. has described a 'risk factor triad' of menopause, pelvic floor disorders and vaginal surgery for trans-vaginal bowel evisceration [4]. The reported incidence of this uncommon complication is 0-7.5%, as per Hur., *et al*. review of literature [5]. This review also looked for the incidence of dehiscence by mode of hysterectomy showing that robotic hysterectomy was carrying the greatest incidence with 2.33% compared to total laparoscoFigure hysterectomy (0.87%), abdominal hysterectomy (0.28%) and vaginal hysterectomy (0.15%) [5].

Vaginal intercourse post operatively has been recognized as a risk factor for evisceration in some cases. Vault malignancy, increased straining due to constipation and menopause were the most probable causes in our patient. This rare complication has been described from 3rd postoperative day to 30 years post hysterectomy [6]. It happened 7 years post hysterectomy in our case. Different techniques of repair of vault breach have been described, including conventional laparotomy to vaginal repair and more recent laparoscoFigure approach and mesh repairs.

No definitive repair was undertaken in our case in view of overall poor survival owing to progressive vault malignancy, keeping postoperative morbidity least. Attempt at Partial colpocleisis failed in retrospect in our patient though. There have been no such attempts documented in past. Colpocleisis is a procedure reserved for women with uterine prolapse who are otherwise poor surgical candidates for hysterectomy. There has been cases of vaginal evisceration following colpocleisis [7], however none after evisceration.

Conclusion

Evisceration of small bowel is a rare and horrifying surgical emergency. Prompt surgical management is key in managing bowel integrity. Final surgical management and route of surgery depends on case to case.

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Conflict of Interest

None

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