Gynecol Surg (2005) 2: 33–34
DOI 10.1007/s10397-004-0080-6

CASE REPORT

C. Daza Manzano · M. A. Martìnez Maestre
C. González Cejudo · I. Peregrín Alvarez

Small bowel and omentum evisceration after abdominal hysterectomy

Received: 4 September 2004 / Accepted: 19 December 2004 / Published online: 22 February 2005

Abstract Intestinal evisceration through the vagina is rare, and transvaginal evisceration after transabdominal surgery is even more rare. Vaginal evisceration is a very rare complication of abdominal hysterectomy, but when this occurs, it is a surgical emergency. Prompt attention is required to prevent further morbidity and potential mortality. The most common organ to eviscerate is the distal ileum, with only two cases of prolapsed omentum having been reported. We present an unusual case of a postmenopausal woman who presented with a vaginal evisceration of the small bowel and omentum after abdominal hysterectomy.

Keywords Transvaginal evisceration · Hysterectomy · Bowel prolapse

Introduction

Hysterectomy is one of the most common major gynecological procedures. Typical complications such as bladder, ureteral, and gastrointestinal injury and vaginal vault prolapse are well documented, but bowel morbidity is uncommon [1].

One rare complication of hysterectomy is evisceration of abdominal contents through the vagina. Most reported cases occurred following vaginal surgery; transvaginal evisceration after transabdominal surgery is uncommon [2, 3]. Since the first report of vaginal evisceration by McGregor in 1907 [4], 59 cases of vaginal evisceration after hysterectomy have been described in the literature and only 19 cases after a prior abdominal procedure [1]. The small bowel is the organ most commonly prolapsed, and only two cases of prolapsed omentum have previously been published [1]. We report a case of a postmenopausal woman with small bowel and omentum transvaginal evisceration 6 months after total abdominal hysterectomy.

Case report

A 52-year-old postmenopausal woman, gravida 4, para 3-0-1-0, had undergone a total abdominal hysterectomy with bilateral salpingo-oophorectomy for uterine leiomyomas and menorrhagia. The vaginal vault was closed with interrupted sutures (Polysorb 0) and was supported by round ligament colpopexy.

She recovered uneventfully and was discharged on the 7th postoperative day. On the 3rd day after discharge, she came to our emergency department complaining of lower abdominal pain and bleeding. Six months later she was readmitted with vaginal bleeding and discharge. Vaginal examination confirmed about 2 cm of small bowel and 10 cm of omentum protruding through two defects in the apex of the vaginal cuff. Laparotomy with a midline vertical incision was performed. On examination the small bowel, which appeared nonischemic, was replaced; however, a thorough examination of the omental pedicle showed a compromised segment, which was resected with intestinal staples. The vaginal tear was sutured with Vicryl. The patient made a remarkable postoperative recovery.

Discussion

Transvaginal evisceration after abdominal hysterectomy is exceedingly uncommon [1–3, 5–7]. Virtanen et al. [8] found 71 cases of transvaginal prolapse, but they included evisceration after all types of procedures and even spontaneous events without a history of previous

C. Daza Manzano (✉)
C/ Alamo n° 23° B, 21006 Huelva, Spain
E-mail: cintadazam@hotmail.com
Tel.: +34-95-9808957
Fax: +34-95-9222308

C. Daza Manzano · M. A. Martìnez Maestre
C. González Cejudo · I. Peregrín Alvarez
Hospital Maternal Virgen del Rocío, Sevilla, Spain

genital operation. In a literature review, Ramírez and Klemer [1] describe 59 cases of vaginal evisceration after hysterectomy, including only 19 cases with a prior abdominal hysterectomy [7] (of whom two had had radical hysterectomy [2, 3] and two had undergone simultaneous procedures for pelvic floor repair).

Bowel prolapse through the vagina has been most frequently reported in postmenopausal women with enterocele and previous vaginal surgery [5]. In premenopausal women it is usually associated with vaginal trauma from coitus, obstetric instrumentation, or a foreign body [9], but cases of vaginal evisceration after hysterectomy in premenopausal women have also been published [7, 9].

The etiology is unclear, but Somkuti et al. [7] identified factors that can contribute to a weakening of the vaginal apex after vaginal or abdominal surgery: (1) poor surgical technique, (2) postoperative wound or cuff infection, (3) wound hematoma, (4) resumption of sexual activity before complete healing, (5) advanced age, (6) previous radiation therapy, (7) chronic steroid administration, (8) trauma and rape, (9) previous vaginoplasty, and (10) Valsalva's maneuver or straining during a bowel movement.

The most common clinical presentation of vaginal evisceration consists of vaginal bleeding, pelvic pain, discharge, or/and a protruding mass [1]. The distal ileum is the most common organ to eviscerate, but prolapse of omentum (only two cases), colon, appendix, and fallopian tubes have been reported [1].

Vaginal evisceration is a surgical emergency. Management begins by stabilizing the patient's condition and providing intravenous hydration and prophylactic antibiotics, followed by examination and surgical repair under general anesthesia [1, 5, 7].

The repair approach used (abdominal, vaginal, or a combined approach) depends on several factors [1]: (1) the viability of the prolapsed bowel and its mesentery, (2) the surgeon's ability to reduce the prolapsed intestine, and (3) the exposure to the operative field; poor exposure may exist secondary to morbid obesity or inability to flex the lower extremities enough to place them in the lithotomy position.

A complete and thorough inspection of the entire mesentery is crucial to assess for lacerations and vascular injuries that could change the patient's management and prognosis.

Various methods have been reported for closing the defect in the vagina and trying to prevent recurrence of this complication. The techniques described include cul-de-sac obliteration, Dacron mesh reinforcement [10], adductor magnus muscle flap [11], vaginectomy, colpocleisis, and others [1, 5, 6].

References

1. Ramirez PT, Klemer DP (2002) Vaginal evisceration after hysterectomy: a literature review. Obstet Gynecol Surv 57:462–467
2. Bashir D (1999) Transvaginal evisceration of small bowel after radical hysterectomy and pelvic lymphadenectomy. Gynecol Oncol 73:165–166
3. Kim Sm, Choi HS, Ji-Su B (2002) Transvaginal evisceration after radical hysterectomy. Gynecol Oncol 85:543–544
4. McGregor AN (1907) Rupture of the vaginal wall with protrusion of small intestine in a woman 63 years of age: replacement, suture, recovery. J Obstet Gynecol Br Emp 11:252–258
5. Kowalski LD, Seski JC, Timmins P, Kanbour A, Kunschner A, Kanbour A (1996) Vaginal evisceration: presentation and management in postmenopausal women. Am J Coll Surg 183:225–229
6. Kunda A (2002) Vaginal evisceration: a report of two cases. J Obstet Gynecol 22:568–569
7. Somkuti SG, Vieta PA, Daugherty JF, Hartley LW, Blackmon EB Jr (1994) Transvaginal evisceration after hysterectomy in premenopausal women: a presentation of three cases. Am J Obstet Gynecol 171:567–568
8. Virtanen HS, Ekholm E, Kiilholma PJ (1996) Evisceration after enterocele repair: a rare complication of vaginal survey. Int Urogynecol 7:344–347
9. Cardosi MD, Hoffman MD, Roberts W (1999) Vaginal evisceration after hysterectomy in premenopausal women. Obstet Gynecol 94:859
10. Crespi C, De Giorgio AM (1991) [Prolapse of the vaginal vault complicated by ileal evisceration. Possible role of Dacron mesh in emergencies. Technical notes] [article in Italian]. G Chir 12:498-500
11. Rolf BB (1970) Vaginal evisceration. Am J Obstet Gynecol 107:369-375