Acute Abdomen In A Rare Case Of Vaginal Evisceration Following Subtotal Hysterectomy

R Clarke, F McGinn

Citation

R Clarke, F McGinn. *Acute Abdomen In A Rare Case Of Vaginal Evisceration Following Subtotal Hysterectomy*. The Internet Journal of Gynecology and Obstetrics. 2006 Volume 6 Number 2.

Abstract

Only a few cases of vaginal evisceration following hysterectomy have been reported in the literature world-wide with even fewer reports after subtotal hysterectomy. A potentially life threatening complication of a very common gynaecological operation should be recognised and treated without delay. History with careful clinical examination and high index of suspicion will ensure a prompt diagnosis and optimum clinical outcome. We report a case of vaginal evisceration following subtotal hysterectomy in a 57 year old lady.

INTRODUCTION

Vaginal evisceration after hysterectomy is a very rare occurrence and only few cases have been documented in the worldwide literature. Hysterectomy is an extremely common procedure performed routinely on a global basis with recognised complications which include infection, bleeding, bladder injury, and prolapse of the vaginal vault. Subtotal hysterectomy with preservation of the cervix may have an advantage over total abdominal hysterectomy, with less operative and post operative complications, quicker recovery and less problems with vaginal shortening and vault prolapse[1, 2]. Informed consent requires a patient to be aware of potentially life threatening complications of surgery, even if they may occur some time after the procedure[3]. The complication of vaginal evisceration, not previously reported with subtotal hysterectomy should not be overlooked, as early assessment, resuscitation and surgery will improve morbidity and mortality.

CASE REPORT

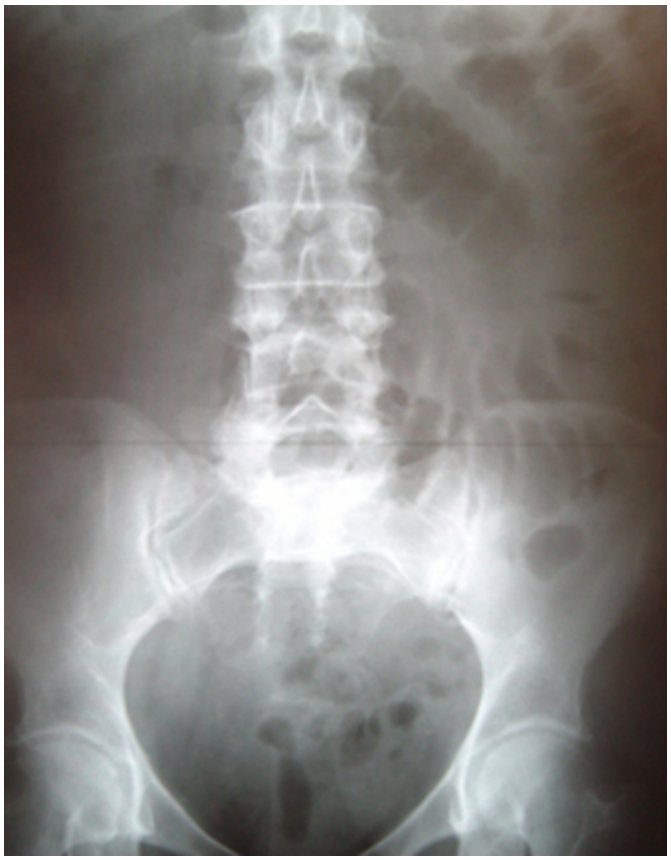
A 57 year old lady presented to the Accident & Emergency department with acute lower abdominal pain. Her past medical history consisted of an uncomplicated subtotal hysterectomy with bilateral salpingo-oophrectomy for large fibroids 5 years previously. Originally planned as a hysterectomy, this operation was converted to a subtotal hysterectomy for technical reasons. Then operation was documented as being a difficult due to the size of the fibroid with an immobile uterus within a deep pelvis. Other medical history included only mild asthma and her medications were HRT and a salbutamol inhaler.

Pain was colicky in nature, worse with movement and radiating to her rectum. There was no change in bowel habit and she was passing stool without difficulty. No nausea or vomiting, no urinary symptoms, vaginal discharge or bleeding were reported. General examination revealed a lady of normal weight, with pain controlled following opiate analgesia. She was apyrexial, had a pulse rate of 60bpm with a blood pressure of 128/79. Her abdomen was soft with tenderness to deep palpation in the suprapubic region. All hernial orifices were clear. Digital rectal examination revealed a tender region with fullness anteriorly at a distance of 10cm from the anal verge. Digital vaginal examination was performed and no abnormalities were noted. Blood tests on admission were all normal. Urinalysis showed trace of blood and leukocytes with subsequent MSU growing staphylococcus aureus. Admission abdominal and chest x-rays were both unremarkable.

Over the next 24 hours the patient remained unchanged from a clinical point of view. She passed no stool or flatus and a single episode of vomiting was reported overnight. On day two she appeared to improve but vomited 500ml of faeculant fluid and a nasogastric tube was inserted. Her abdomen remained soft but slightly distended. A repeat abdominal X-ray (fig 1) demonstrated small bowel dilatation and she was prepared for theatre.

Figure 1

Figure 1



An exploratory laparotomy demonstrated small bowel obstruction, with adhesions holding the jejunum to the anterior abdominal wall. In the pelvis a distal segment of small bowel had herniated and incarcerated into the vagina through an opening in the vaginal vault. The bowel itself was congested but viable. The herniated bowel was reduced, and the deficiency in the vaginal vault was closed using interrupted vicryl suture. Intravenous cefuroxime and metronidazole were given at induction but not continued.

The patient made an uncomplicated recovery and was discharged 5 days after her laparotomy.

DISCUSSION

Vaginal evisceration after hysterectomy is a very rare occurrence. A total of 59 cases being reported in the literature since 1900[4]. These can generally be separated according to their aetiology, either premenopausal women or postmenopausal women. The premenopausal cases, which appear to be even rarer, tend to be associated with either sexual or obstetric trauma. Postmenopausal women are usually elderly, with associated atrophic vaginal walls which have an increased risk of rupture. Any conditions leading to a raised intra-abdominal pressure may well predispose to evisceration.[5] Medications such as long term steroids may also play a role in vaginal atrophy and wall weakness[6].

Previous reports have demonstrated evisceration following vaginal, total and laparoscopic hysterectomy, but searches show no documented cases following subtotal hysterectomy. Subtotal hysterectomy, with cervical preservation should reduce the risk of bowel prolapse, however in this case prolapse with evisceration has still occurred. Technical operative difficulty, possibly the cause with this patient, as well as poor operative technique and localised infection will increase the risk of evisceration. In all reported cases small bowel appears to be the most common intra abdominal organ involved [7].

A thorough history and examination, both surgical as well as gynaecological must never be overlooked. Vaginal examination including speculum in this case would have been very helpful. Vaginal evisceration remains a rare complication of hysterectomy, however it is a potentially life threatening condition and recognising it early will improve patient outcome. Although this patient presented acutely with incarceration, the clinician should be aware that other reported cases have had a more chronic presentation, without obvious necessity for immediate intervention.

References

1. Hasson HM, J Reprod Med. Cervical removal at hysterectomy for benign disease. Risks and Benefits. 1993 Oct; 38(10): 781-90
2. Thakar R, Ayers S, Clarkson P, Stanton S, Manyonda I. Outcomes after total versus subtotal abdominal hysterectomy. N Engl J Med. 2002 Oct 24; 347(17): 1318-29
3. Feiner B, Lissak A, Kedar R,Lefel O, Lavie O. Vaginal evisceration long after vaginal hysterectomy. Obstet Gynecol. 2003 May; 101(5 Pt 2): 1058-9
4. Ramirez PT, Klemer DP. Vaginal evisceration after hysterectomy: a literature review. Obstet Gynecol Surv. 2002 Jul; 57(7): 462-7
5. Kowalski LD, Seski JC, Timmins PF, Kanbour AI, Kunschner AJ, Kanabour- Shakir A. Vaginal evisceration: presentation and management in postmenopausal women. J Am Coll Surg. 1996 Sep; 183(3):225-9.
6. R.V. Patankar, S.D. Scott, F.P McGinn. Intestinal prolapse through the vagina. Postgrad Med J (1993) 69, 818-819.
7. Rollinson D, Brodman ML, Freidman F Jr, Sperling R. Transvaginal small- bowel evisceration: a case report. Mt Sinai J Med. 1995 May; 62(3): 235-8.

Author Information

R .G. Clarke, MRCS
St Mary's Hospital NHS Trust

F. P. McGinn, FRCVS
St Mary's Hospital NHS Trust