



CASE REPORT

Vaginal Evisceration Following Colpocleisis and Sacrocolpopexy

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Abstract

Vaginal vault dehiscence with evisceration is a rare complication after hysterectomy. Early recognition and surgical intervention are required to prevent morbidity and mortality. There is however no consensus as to the optimal surgical approach to repair the vaginal defect and prevent recurrence. We present the extremely rare case of vaginal vault dehiscence with evisceration in a postmenopausal woman with a prior history of both colpocleisis and sacrocolpopexy to treat recurrent post-hysterectomy vault prolapse.

Keywords: Evisceration; Colpocleisis; Sacrocolpopexy

Introduction

Vaginal vault dehiscence with evisceration is a rare complication after hysterectomy [1]. Evisceration after pelvic floor surgery such as colpocleisis or sacrocolpopexy is even rarer. Although this situation constitutes a surgical emergency, there is no consensus as to the optimal approach for treatment and further prevention [2].

Case

An 89-year-old woman presented for gynaecological review in 2015 with complete eversion of the vaginal vault, having had vaginal hysterectomy performed 30 years earlier. In view of her medical comorbidities, conservative management with various pessaries was attempted but was ultimately unsuccessful. With sexual intercourse no longer desired, colpocleisis was performed with concomitant perineorrhaphy. Within six months however the patient returned with recurrent eversion of the vault and denuded vagina. Repeat colpocleisis was considered but not recommended due to the poor quality of the vaginal epithelium. She then proceeded to further surgical intervention with laparoscopic sacrocolpopexy.

Twenty months later, the patient presented to the emergency department with acute onset of spontaneous abdominal pain and vaginal bleeding. Her vital signs were stable and there was no abdominal peritonism. Upon inspection of the external genitalia, multiple loops of bowel had eviscerated through the vagina (Figure 1). Following the administration of intravenous fluids and broad-spectrum antibiotics, the exposed bowel was protected with saline-soaked gauze and prompt transfer to the operating theatre was arranged.

In Trendelenburg position, the bowel was carefully replaced through the vagina. A midline infra-umbilical laparotomy was performed to assess the viability of the bowel, however peristalsis was observed and resection was not required. While the vault remained well suspended, the anterior and posterior sacrocolpopexy mesh leaflets had separated. The 3cm defect along the apex was closed with a delayed absorbable suture. The patient recovered well and the vault was intact at the post-operative visit.

Discussion

Vaginal evisceration is a rare complication that affects 0.39% of women following hysterectomy [3]. Recurrence is even more rare, with just two cases reported in the literature between 1900 and 2002 [1]. Early recognition is important, as potential morbidity arising from bowel ischaemia, perforation and sepsis contributes to a mortality rate that approaches 6-10% [4].



Figure 1: Vaginal vault dehiscence with small bowel evisceration

Early resumption of intercourse is usually the precipitating factor for evisceration in premenopausal women, while it is more likely to be a spontaneous event or upon increased abdominal pressure in postmenopausal women [1]. This patient was at particular risk due to the combination of vaginal atrophy and multiple operations for pelvic floor weakness. Additional risk factors in general also relate to poor tissue healing, such as diabetes mellitus, malnutrition, corticosteroid use, malignancy, radiation therapy and post-operative infection or haematoma [5]. The traditionally held view that the risk of cuff dehiscence is increased with minimally invasive hysterectomy technique has been challenged by recent prospective data [6].

Following stabilisation of the patient, the principles of management include reduction of the eviscerated contents and evaluation of bowel viability. Laparotomy is only necessary if resection is considered likely. Surgical repair of the vaginal defect can be performed by any of the abdominal, vaginal or laparoscopic routes. In this case, reinforcement with a synthetic graft was not considered in the presence of existing mesh, and in hindsight an omental flap may have conferred additional protection [4]. There is however no clear evidence as to the optimal surgical management. Sacrocolpopexy and colpocleisis have both been proposed as surgical measures to prevent recurrence, however case reports have described evisceration following each of these procedures [7,8]. To our knowledge, this is the first case report of evisceration following both.

Conclusion

Evisceration from the vaginal vault is a rare complication and an emergency for which the surgical management is challenging and requires an individualised approach.

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