Spontaneous transvaginal evisceration of small bowel

Michał Kisielewski1, Piotr Richter2

Introduction

Spontaneous evisceration of small bowel through vagina is a very rare clinical condition – there were less than 100 cases reported worldwide [1]. Risk factors for transvaginal evisceration of small bowel are: old age, postmenopausal period, history of hysterectomy or other surgical/instrumental procedures on the pelvic floor, sexual assault and trauma/mechanical injury to the vaginal wall (main cause in premenopausal patients), sudden rise in abdominal pressure [2, 3, 4]. Patients with irreducible bowel loops and risk of necrosis and/or signs of peritonitis should be qualified for emergency surgery [5].

Patient description

An 86-year-old postmenopausal female was brought to the emergency department by family due to the presence of an abnormal mass protruding through vagina for several hours. Additionally, the patient reported nausea and vomiting. Relevant medical history included: 2 vaginal deliveries and trial treatment of pelvic organ prolapse 6 years ago with vaginal pessary (removed during gynaecological follow-up after one year of use). Previous abdominal surgery included appendectomy and cholecystectomy many years before. Moreover, the patient suffered from chronic heart failure and hypertension which were untreated. On physical examination she was haemodynamically stable but disoriented and confused, with soft painless abdomen and peristaltic sounds. After removing the gauze covering the perineal area, approximately 60 cm of small bowel protruding from the vagina was discovered (Figure 1). Bowel loops were irreducible, but viable, without visible signs of necrosis.

Treatment

The patient was qualified for emergency surgery. After induction of general anaesthesia, patient was placed in a gynaecological position. The defect in the posterior aspect of vaginal vault was identified using a lower midline vertical laparotomy (Figure 2). After reduction of small bowel loops to the peritoneal cavity (Figure 3), the defect that was unsuspected for malignancy, having regular borders, was closed with 2 layers of running sutures. No small bowel resection was needed (Figure 4). Additionally, owing to previous history of pelvic organ prolapse, the vagina was fixed to the uterus with several interrupted sutures. A drain was left in the Douglas pouch.
Images

Figure 1. Spontaneous transvaginal evisceration – patient on admission.
Figure 2. Intraoperative image – herniated small bowel through spontaneous perforation of posterior vaginal vault.
Figure 3. Perforation in posterior vaginal vault.
Further postoperative period was surgically uncomplicated – the abdomen was soft, peristalsis was normal, patient had normal stool on 2nd postoperative day. Peritoneal drainage was unremarkable and drain was removed on day 3. Wounds were healing normally, without signs...
of infection. Intravenous fluid therapy and preoperative antibiotics prophylaxis with ceftriaxone were continued for 2 days. Thrombosis prophylaxis with low molecular weight heparin was used during hospitalization.

In the postoperative period, signs of delirium were becoming prominent in the evenings but without any clinical implications. Despite the treatment, patient unexpectedly died on postoperative day 4 due to cardiopulmonary failure.

References


Conflict of interest: none declared

Authors’ affiliations:
1 2nd Department of General Surgery of Jagiellonian University Medical College in Cracow, Poland
2 1st Department of General Surgery of Jagiellonian University Medical College in Cracow, Poland

Corresponding author:
Michał Kisielewski
ul. Kopernika 21
31-501 Kraków
Poland
e-mail: kisialeuskim@gmail.com

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