Letters to the Editor

Spontaneous vaginal evisceration

Key words: Vaginal evisceration. Hysterectomy.

Dear Editor,

Spontaneous vaginal evisceration is a rare phenomenon. Since McGregor reported the first case in 1907 (1), approximately 100 cases of vaginal evisceration were reported in the worldwide literature. Usually occurs in postmenopausal women with previous gynecologic surgery.

Case report

We present a new case of spontaneous vaginal evisceration in a postmenopausal woman. The patient is a 77-year-old woman with personal event of vaginal hysterectomy 13 years before. She was admitted to emergency department because she felt a sudden protrusion of small bowel through the vagina since one hour, after a crisis of laugh in her home. At physical examination we saw about one meter of small bowel with congestive color and active peristalsis prolapsed through the vagina (Fig. 1). An emergency surgery was indicated.

The emergent surgery was made with the collaboration of the gynecology department with a combined abdomino-vaginal approach. An infraumbilical median laparotomy revealed a rupture in the upper posterior wall of the vagina and loops of ileum eviscerated. The small bowel with a good viability was pushed back into the abdomen and the vaginal defect was repaired with unresorbable suture. A Dual mesh was used to reinforce the vaginal suture and the peritoneum was sewed using a resorbable suture.

The patient had an uneventful postoperative course and she was discharged on the fifth postoperative day. At six months of follow-up the patient is asymptomatic.

Discussion

The principal etiology of the vaginal evisceration is the previous vaginal surgery, especially after hysterectomy. The major

Fig. 1. Vaginal evisceration of small bowel.

incident is observed in the vaginal hysterectomy, followed by abdominal hysterectomy related to a radical hysterectomy when the vaginal wall has not been closed and the laparoscopic hysterectomy (2). Usually occurs in patients with postmenopausal hypoestrogenism and atrophy of the gynecological structures, being the increase of the intraabdominal pressure a factor that contributes, like could have been in our case the crisis of laugh that the patient was recounting. In premenopausal women vaginal evisceration is associated with vaginal trauma during coitus, violations, obstetric instrumentation or the presence of a foreign body (3).

Somkuti et al. (4) in 1994 described risk factors for vaginal evisceration: poor surgical technique, postoperative wound or cuff infection, wound hematoma, resumption of sexual activity before complete healing, advanced age, radiotherapy, chronic steroid treatment, vaginal trauma, previous vaginal surgery and Valsalva maneuver. Ileum is most commonly protruding viscus, although other organs, such as the omentum, salpinx and epiploic appendices have also been describe (5,6).

Vaginal evisceration is a surgical urgency. The surgery depends on the type and viability of the eviscerated organ and can be realized by vaginal, abdominal or combined laparotomic or laparoscopic approach (4). The first thing is the reintegration of the prolapsed organs, thorough inspection of the intestinal loops and segmental intestinal resection in cases of severely damaged intestinal tracts (3,4). Later the vaginal defect is repaired by points of unresorbable material, though in some cases also resorbable materials have been used (3).

The decision to proceed to the repair of the pelvic floor defect in the same intervention or in a second time depends on the quality and viability of the structures. Some authors prefer de-

laying the treatment of the enterocele to a second intervention, generally with a reinforcement of the vaginal wall with cardinal or utero-sacral ligaments, or using a sacropexia (2-4).

Marlén Alvite-Canosa¹, José Rivas-Duro²,
Dolores Fandiño-García², Ana Álvarez-Gutiérrez¹,
Inmaculada Monjero-Ares¹, Isabel Pérez-Moreiras¹,
Eva Iglesias-Porto¹, Rocío González-López¹,
José Antonio Costa-Bujan¹ and Félix Arija-Val¹

*Departments of ¹General and Digestive Surgery,
and ²Gynecology and Obstetrics. Complejo
Hospitalario Xeral-Calde. Lugo, Spain*

References

1. McGregor A. Rupture of the vaginal wall with protrusion of small intestines in a woman 63 years of age. Replacement, suture, recovery. *J Obstet Gynecol Br Emp* 1907;11:252.
2. Bernal JC, Iglesias R, Landete FJ, García M, Morera F, Ripoll F, et al. Evisceración vaginal. Abordaje abdominal y reparación con malla sintética. *Prog Obstet Ginecol* 2009;52(2):109-11.
3. Sánchez JM, Naranjo A, Ciria R, Gallardo JM, Rufián S. Evisceración vaginal. *Cir Esp* 2008;84(2):101-11.
4. Somkuti SG, Vieta PA, Daugherty JF, Hartley LW, Blackmon EB. Transvaginal evisceration after hysterectomy in premenopausal women: a presentation of three cases. *Am J Obstet Gynecol* 1994;171:567-8.
5. Bueno K, Serralta A, Planells M, Dobón F, Ibáñez F, López F, et al. Evisceración vaginal. Aportación de 3 casos. *Cir Esp* 2002;71(2):89-91.
6. Powell JL. Transvaginal evisceration after hysterectomy. *Am J Obstet Gynecol* 1995;172:1656.