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GI IMAGE

Transvaginal Evisceration

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A 78-year-old female with past medical history of invasive bladder cancer was treated with neoadyuvant chemotherapy and surgery. In February 2022, it was performed a complete robotic bladder resection, urinary diversion with a Bricker technique, and total abdominal histerectomy with bilateral oophorectomy and lymphadenectomy. The postoperative period was uneventful, and the patient was discharged from the hospital 4 days after the surgery. During the ambulatory follow-up, the patient was diagnosed with vaginal and rectal prolapse.

Eight months later, the patient presented to the Emergency Department with intense pelvic and lower abdominal pain after an episode of nausea and vomiting, associated with a pelvic mass. The physical examination revealed a transvaginal evisceration of the small bowel (Fig. 1). After applying temporary containment of the intestinal loops and irrigating them with topical hypertonic glucose solution, the patient was immediately taken to the operating room. She underwent a midline laparotomy, with reduction of the bowel into the abdominal cavity. It was evidenced a 5-cm defect in the vaginal vault that was repaired with simple stitches (absorbable suture) (Fig. 2). No bowel resection was necessary (bowel without ischemia or perforation), and the Bricker ileal conduit was unscathed. After a mild COVID-19 postoperative infection, the patient made full recovery and was sent home 7 days after the intervention.

Transvaginal bowel evisceration is a rare surgical condition. The first case was reported in 1864 by Hypernaux et al., and a limited number of cases have been published since then.[1] The risk groups for this surgical emergency include postmenopausal women, women who had past medical history of vaginal or uterine surgery, and patients with concomitant pelvic organ prolapse. The increase incidence in this group has been associated with decreased vascularization and vaginal wall atrophy.[2] Premenopausal women can also be affected, but it is infrequent and more related to vaginal trauma or sexual activity .[1] Many other factors can favor the onset of this surgical complication: elderly, obesity, radiotherapy, hypothyroidism, multiparous women, but most cases reported always described a situation increasing the intra-abdominal pressure in the context of pelvic floor weakness as a trigger moment for the evisceration (trauma, surgery, coughing, constipation, vomits).[3] Patients usually present with abdominal pain, vaginal bleeding, and vaginal mass.[1] Our patient was a postmenopausal woman who underwent recent bladder and uterine surgery, diagnosed with postoperative vaginal and rectal prolapse, and who experienced a transvaginal evisceration after having nausea and vomits.

Transvaginal small bowel evisceration carries high rates of mortality and morbidity (6–8% and 15–20%, respectively).[3] Within its management, emergency surgery is a priority, and any delay in surgical intervention could eventually lead to gut injury, ischemia, bowel resection, sepsis, and death. Prompt reduction of the small bowel is necessary, and it must be carefully examined to evaluate its vitality.[2] Transvaginal and transabdominal approaches have been used, and both have equal rates of recurrence and complications; the choice must be done depending on the clinical presentation of the patient. In 20% of cases, it is necessary to perform a bowel resection and anastomosis,[1] followed by repair of the vaginal defect.

In conclusion, transvaginal evisceration is a life-threatening and infrequent pathology. It requires urgent diagnosis and emergency surgical treatment to prevent small bowel ischemia and its complications. If the eviscerated bowel is nonviable, resection and anastomosis should be done.

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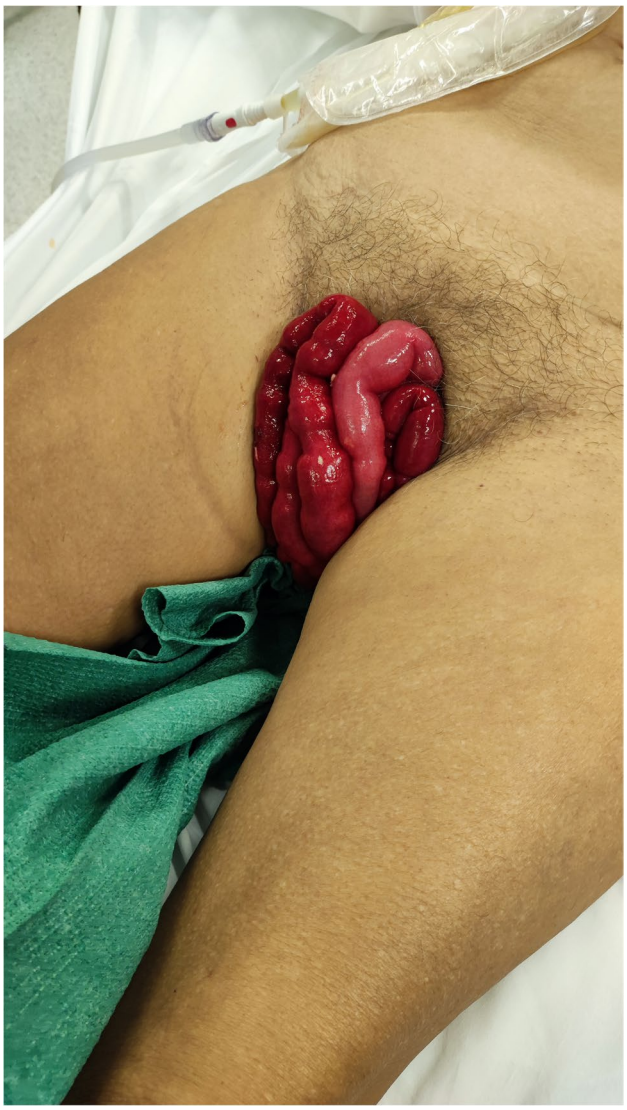

Fig. 1 Small bowel transvaginal evisceration

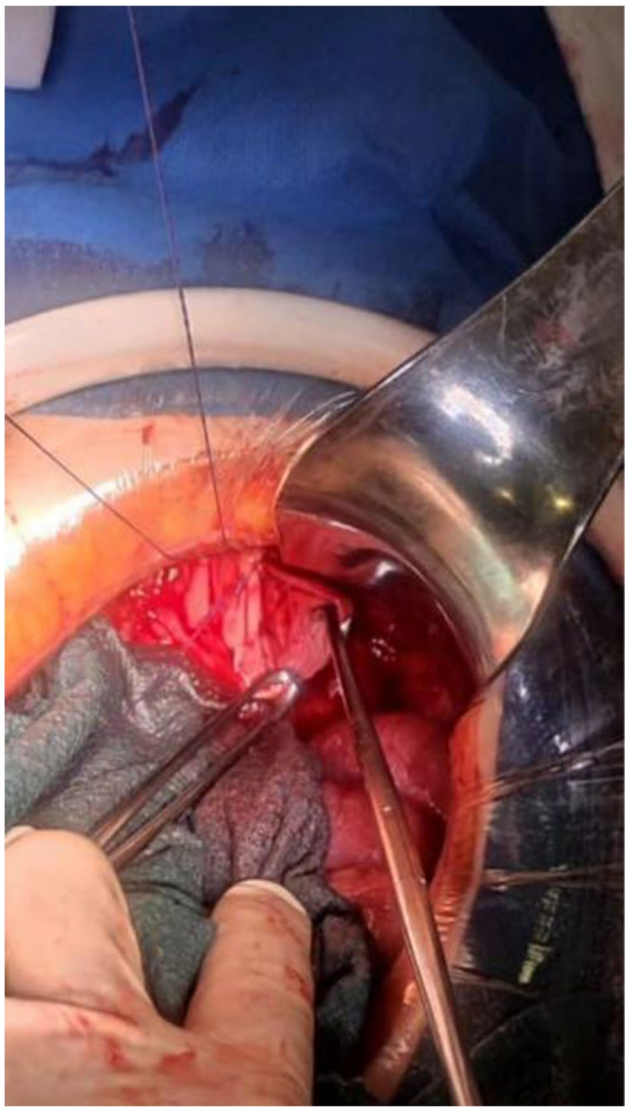

Fig. 2 Defect in the vaginal vault

Data Availability Data available on request from the authors.

Declarations

Ethics Approval Written informed consent was obtained from the patient for publication of this case report and all images included. The confidentiality of the data is guaranteed by the authors.

Conflict of Interest The authors declare no competing interests.

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