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Unusual presentation of more common disease/injury

Spontaneous vaginal evisceration

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Summary

Management of vaginal prolapse in the elderly lacks a uniform consensus and continues to remain challenging. The authors report a case of an elderly lady who presented with a spontaneous vaginal evisceration. She had a long-standing vaginal prolapse being controlled by a shelf pessary, which, in her case became displaced 2 weeks prior to admission. The patient underwent a laparotomy with an intent to replace the bowel back within the peritoneal cavity and repair the vault. During the pelvic floor repair, she sustained an inadvertent button-hole injury to the rectum, which was oversewn. She went on to develop a rectovaginal fistula requiring a de-functioning colostomy. The patient made good recovery subsequently.

CASE PRESENTATION

A frail 79-year-old lady presented to the A&E with abdominal pain and blood-stained vaginal discharge for the past 48 h. Concurrent co-morbidities included atrial fibrillation, ischaemic heart disease and a recent stroke. A long-standing genital prolapse had been managed with a shelf pessary as the patient had declined surgical intervention. The patient's co-morbidities made her a high-risk candidate for surgery. At presentation, the patient's shelf pessary had been displaced for 2 weeks.

The patient was haemodynamically stable. Physical examination was normal. Vaginal examination, however, revealed loops of small bowel herniating through the introitus. The bowel appeared healthy and pink and exhibited normal peristalsis (figure 1).

TREATMENT

The patient was taken to the theatre for a laparotomy with an intent to reduce the herniated bowel and repair the vaginal vault.

A large transverse defect approximately 4×4 cm was found in the posterior fornix along with a cystocele and rectocele. A vaginal hysterectomy with an anterior and posterior colporrhaphy was performed. The defect in the posterior fornix was excised and closed obliterating the cul-de-sac.

There was an inadvertent button-hole injury to the rectum during the repair, which was oversewn. She was discharged home 12 days later.

OUTCOME AND FOLLOW-UP

Sixteen weeks later, the patient presented with feculent discharge from the vagina. Subsequent imaging confirmed a rectovaginal fistula. The fistula was repaired at laparotomy and a de-functioning colostomy was performed. The patient made good recovery and was lost to follow-up after 2 years.

DISCUSSION

Management of vaginal prolapse in the elderly lacks a uniform consensus and continues to remain challenging.[1] Spontaneous vaginal evisceration is rare or at least so severely underreported that no incidence rates can be established in the literature.[2 3] This complication is becoming more common and may be associated with increasing numbers of total laparoscopic and robotic hysterectomies.[4–6]

Vaginal evisceration primarily affects postmenopausal women. Pelvic floor repair, vaginal or abdominal hysterectomy and the presence of an enterocele are considered as important risk factors for evisceration.[7–9]

Prompt diagnosis and urgent management is critical to avoid small bowel complications including ischaemia, obstruction or strangulation. Surgical repair of the evisceration can be undertaken through a vaginal, abdominal or an abdominovaginal approach. Recently, laparoscopy-assisted techniques are being used to manage the complication.[10–12] Colpocleisis and vaginectomy have also been performed to treat vault evisceration.[13] A laparotomy may be needed if bowel injury is suspected.

A pelvic floor repair can be done at the same time or electively at a later date. A review at the Mayo Clinic Rochester showed no excess morbidity with immediate repair.[14]

Our patient sustained a rectal (button-hole) injury during the repair, which was promptly identified and repaired. Unfortunately, she developed a rectovaginal fistula 4 months later. Owing to the poor quality of her vaginal

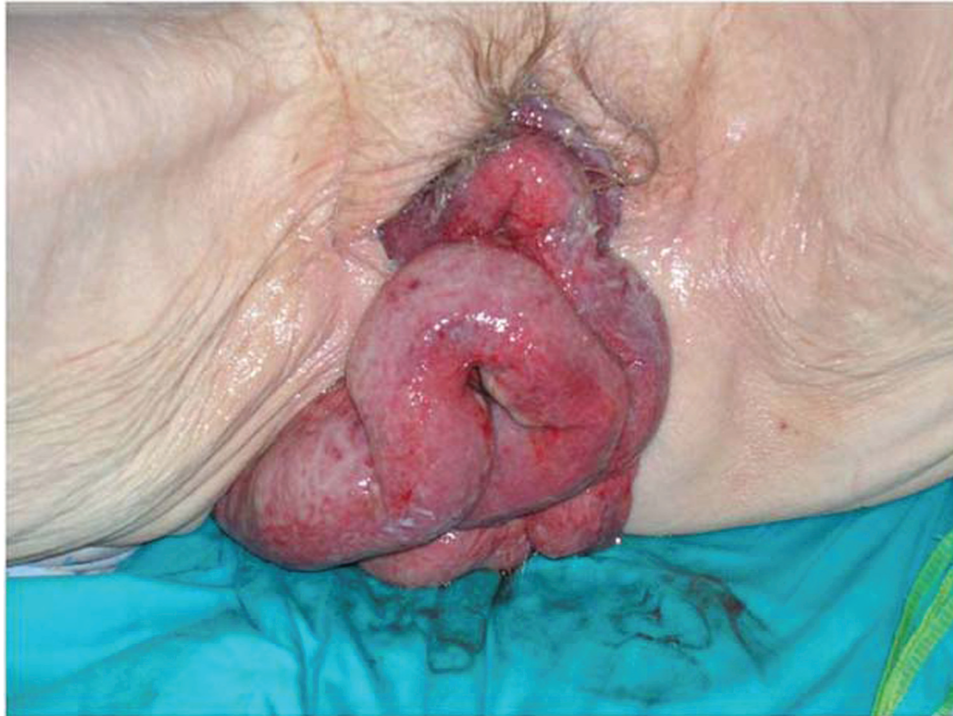

Figure 1 Vaginal eviscerations.

tissues it could be argued that a delayed repair might have been more appropriate. However, this was felt inappropriate at the time due to her high anaesthetic risk for any future surgery.

Learning points

- Vaginal evisceration is a potentially life threatening but fortunately rare condition. Prompt recognition and immediate surgical therapy is needed for a successful outcome.
- Pesseries in the frail and elderly patients should be monitored closely as they are more prone to develop complications such as fistulas, incarceration and vaginal evisceration.
- Choosing the right pessary, improving the vaginal wall integrity with local oestrogen cream along with patient education and a vigilant follow-up can reduce such complications.
- There has been a recent reported increase in the incidence of vaginal cuff dehiscence and evisceration with total laparoscopic hysterectomy and robotic total laparoscopic hysterectomy.

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Competing interests None.

Patient consent Obtained.

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