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Small bowel evisceration through the vaginal wall – A rare surgical emergency

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Abstract

Transvaginal small bowel evisceration is a rare but life-threatening surgical emergency that is associated with vaginal cuff dehiscence following hysterectomy. Prompt recognition and urgent operative management are essential to prevent bowel ischaemia, perforation and sepsis.

We present a case of a 36 -year-old female with a history of vaginal hysterectomy for endometrial cancer on chemotherapy who presented with acute evisceration of small bowel through the vaginal. The bowel loops at examination were oedematous and hyperaemic without overt signs of ischaemia. She was resuscitated and underwent laparoscopic reduction with repair of the vaginal defect.

This case highlights a rare surgical emergency reported in elderly patients following hysterectomy, now presenting in the young with significant predisposing risk factors.

Early diagnosis and timely surgical intervention are key in preventing catastrophic complications of bowel ischaemia, perforation and sepsis.

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Introduction

Small bowel evisceration through the vaginal wall is a rare surgical emergency characterised by extrusion of small bowel loops through a defect in the vaginal vault [1]. It poses significant clinical implications, primarily due to its potential for severe complications such as strangulation and infection [2]. This condition is rare with an overall low incidence but carries a significant risk of bowel ischaemia, strangulation, peritonitis and sepsis necessitating immediate recognition and operative intervention [3].

The principal mechanism underlying this condition is vaginal cuff dehiscence, reported after minimally invasive hysterectomy due to altered tissue handling, thermal injury and variations in suturing techniques [4].

Additional predisposing factors include post-menopausal atrophy, sexual intercourse, increased intra-abdominal pressure, pelvic weakness, traumatic events such as unsafe abortion and prior radiotherapy [3].

Clinically, patients often present with acute pelvic pain, vaginal bleeding and the alarming visualisation of bowel loops at the vaginal introitus.

The surgical management often necessitates prompt intervention, typically involving the reduction of the eviscerated bowel and repair of the vaginal wall defect through laparoscopic or open techniques to minimise morbidity [5].

Although patient outcomes vary, it is heavily influenced by factors such as the timing of surgical intervention and the overall patient's health status. Many recovers without significant complications. Delays in treatment can lead to increased mortality rates and adverse long-term effects on bowel function [6].

Given its dramatic presentation and potential for catastrophic outcome, small bowel evisceration requires heightened clinical awareness and swift multidisciplinary management.

Case presentation

We present a case of a 36-year-old female with a history of vaginal hysterectomy for endometrial cancer who presented with sudden onset abdominal pains described as sharp and constant. She also reported one episode of vomiting and open bowel as normal.

The patient's detailed history showed she had constipation for about a week that increased her intra-abdominal pressure. She had undergone a vaginal hysterectomy for endometrial cancer and was on chemotherapy.

In the emergency department, the patient's blood pressure was 111/70 mmHg, heart rate was 90 bpm, in sinus rhythm and her temperature was 36.9 degrees centigrade. Her venous blood gas showed a PH 7.58 and lactate of 3.5

She required intravenous analgesia and fluid resuscitation. On examination, her abdomen was mildly distended, soft and tender in the suprapubic area. Perineal examination showed bowel loops in the vaginal introitus that were hyperaemic without signs of ischaemia.

A urethral catheter was inserted and a nasogastric tube inserted to decompress the stomach. An urgent Anaesthetic assessment was undertaken, and she was transferred to the operating theatre.

A laparoscopy with reduction of small bowel herniation from the vaginal vault and closure of vault defect was performed.

Intra-operatively, small bowel loops within the vaginal were congested and hyperaemic but not ischaemic. They were reduced with no enterotomy, vaginal vault was closed with stratifix0 stich in a single layer, and a pelvic drain was left in situ.

Her recovery was uneventful, pelvic drain was removed at post-operative day 4 and she was discharged home.

Discussion

Transvaginal small bowel evisceration is a rare but potentially life-threatening surgical emergency characterised by protrusion of intra-abdominal viscera through a defect in the vaginal wall. Although rare, it requires rapid recognition and urgent surgical management to prevent bowel ischaemia, necrosis and sepsis. The condition most frequently occurs in patients with a history of pelvic surgery, particularly hysterectomy, which predisposes to weakening of the vaginal cuff [3].

In the index case, a 36-year -old woman with a previous vaginal hysterectomy for endometrial cancer presented with sudden abdominal pain and vomiting, accompanied by bowel loops protruding through the vaginal introitus. Her history of constipation and increased abdominal pressure likely acted as a precipitating factor for vaginal cuff rupture and subsequent evisceration. Increased intra-abdominal pressure from activities such as straining, coughing or defecation has been widely reported as a trigger for this condition in susceptible individuals [7].

Vaginal cuff dehiscence with bowel evisceration is more commonly reported following hysterectomy procedures, particularly minimally invasive or vaginal approaches. Surgical disruption of the vaginal apex leads to weakening of tissue integrity, and postoperative healing may be compromised by factors such as infection, poor tissue vascularity, malignancy, or adjuvant therapies like chemotherapy or radiotherapy [1].

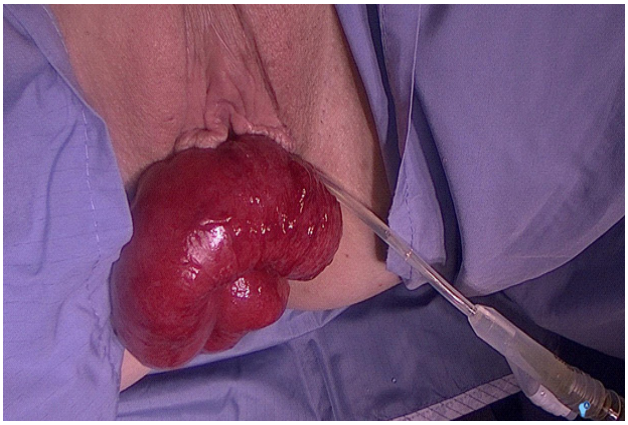

Figure 1: Small bowel loops at the vaginal introitus.

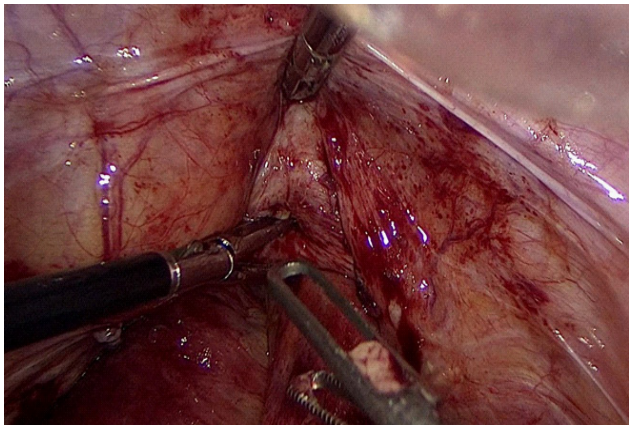

Figure 2: Small bowel loops through the vaginal vault at laparoscopy.

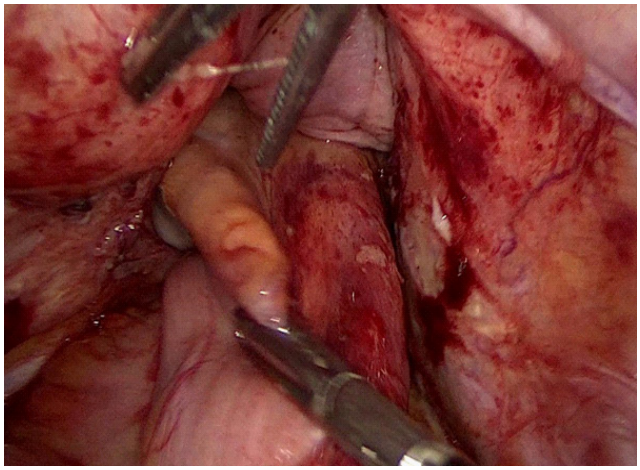

Figure 3: Ongoing reduction of small bowel loops.

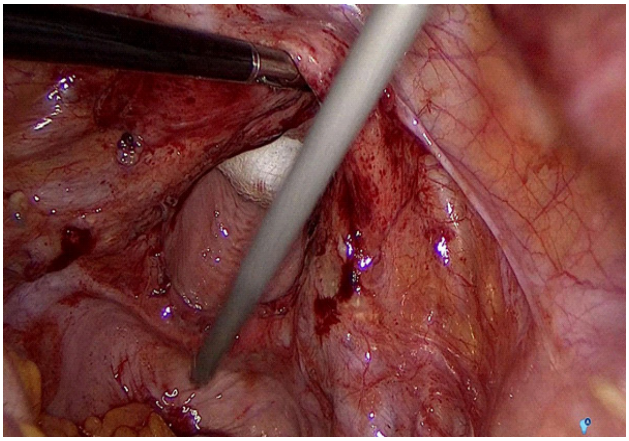

Figure 4: Bowel loops reduced with visible vaginal wall defect.

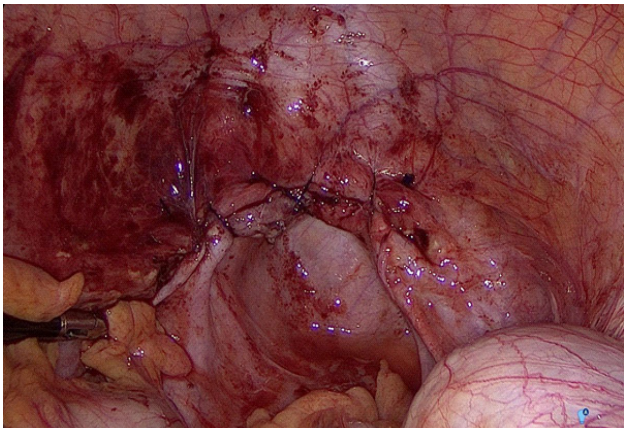

Figure 5: Vaginal wall defect repaired.

In this patient, the history of endometrial cancer and ongoing chemotherapy may have contributed to impaired tissue healing and increased vulnerability of the vaginal cuff.

The clinical presentation of vaginal evisceration varies but typically includes sudden pelvic or abdominal pain, vaginal bleeding or the sensation of a mass protruding through the vagina. In severe cases, small bowel loops may visibly protrude through the vaginal introitus, as observed in this patient. Prompt recognition during physical examination is crucial, as delays in treatment significantly increase the risk of bowel strangulation and ischaemia [8]. In this case, perineal examination demonstrated hyperaemic bowel loops without signs of ischaemia, suggesting an early presentation before vascular compromise.

The Management of transvaginal bowel evisceration is considered a surgical emergency. Immediate steps include protecting the exposed bowel with warm saline-soaked sterile gauze, administering broad-spectrum antibiotics, and preparing the patient for urgent surgical repair [3]. Surgical management typically involves reduction of the herniated bowel and repair of the vaginal defect, which may be approached via abdominal, vaginal or combined surgical techniques depending on bowel viability and the extent of the defect [7]. Early intervention is associated with favourable outcomes and preservation of bowel integrity.

Conclusion

Transvaginal small bowel evisceration is a rare but serious complication following hysterectomy. This case highlights the importance of recognising predisposing factors such as previous pelvic surgery, chemotherapy, and increased intra-abdominal pressure. Early clinical recognition and prompt surgical management are essential to prevent life-threatening complications such as bowel ischemia and peritonitis.

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