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RESEARCH ARTICLE

A Case of vaginal cuff dehiscence with bowel evisceration after five years from hysterectomy

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ABSTRACT

To report a case of vaginal cuff dehiscence with bowel evisceration after total abdominal hysterectomy and discuss the risk factors, prevention and treatment alternatives of this unusual gynecologic emergency. A 79-year-old woman presented to the emergency clinic with vaginal cuff dehiscence with bowel evisceration, developed 5 years after total abdominal hysterectomy and bilateralsalping ooophorec to my for post menopausal adnexalmass. Approximately 130 cm bowel loops with mesentery from the cecum was torsioned and herniated from eviscerated vaginal cuff. The patient was taken to emergency laparoto my and was prepared in lowlitho to my position. The bowelloops were detorsioned, inducted into abdomen from median inferior incision and vaginal vault was sutured continuously with No.1 vicry l. Second line interrupted sutures of vaginal vault were made with 2.0 polydioxanone sutures. As a result VCD is a rare but serious complication that can be seen in any time after hysterectomy. Further investigations need for its prevention and ideal method of repair.

INTRODUCTION

Vaginal cuff dehiscence (VCD) is a separation of the vaginal incision after a total hysterectomy, allowing abdominal contents protruding into the vagina. VCD with bowel eviscreation is creation is a serious complication of hysterectomy to my that requires urgent surgical intervention.

Case Report

A 79-year-old hypertensive woman was admitted to emergency clinic with a mass between her legs and severe abdominal pain. She had history of total abdominal hysterectomy (TAH) and bilateral salpingooophorectomy to my for post menopausal adnexal mass which was resulted benign five years ago. Her examination demonstrated prolapsed strangulated bowel loops from eviscerated vaginal cuff. She was taken to emergency laparotomy by general surgery and gynecology units. She was prepared in low lithotomy position and herniated bowel loops were washed with warm salin solution (Figure 1a). Abdominal exploration with a median inferiorincision was showed that 130 cm bowel loops with mesentery from the caecum was torsioned and herniated from eviscerated vaginal cuff. The bowel loops was detorsioned, inducted into abdomen and washed with about 2000 ml warm salin solution by general surgery team. There were no perforation or necrosis in the bowel loops and the perfusion of the bowel loops was improved with time. The vajinal valut was observed as completely separated approximately 3.5-4 cm (Figure 1b).

The bladder peritoneum was detached with sharp dissections from the vaginal vault. After the corner suture, vaginal vault was sutured continuously with No.1 vicryl. Second line interrupted sutures of vaginal vault were made with 2.0 PDS (Figure 1c). She was given total parenteral nutrition, piperacillin –tazobactam, metronidazole and low-molecular weight heparin treatment. Her oral nutrition was began gradually from the post operative sixth day and she was to lerated well. She was discharged at post operatively twelfth day with healing.

DISCUSSION

All patients who had hysterectomytomy must be informed about VCD and must be alert for sudden onset pelvic or abdominal pain accompanied by vaginal bleeding or watery discharge. VCD has been reported as early as 3 days and as late as 30 years post operatively (Cardosi, 1999; Moen, 2003). The mean time for VCD was varied between 6.1 weeksupto 1.6 years (range 2 weeks to 5.4 years) (Agdi *et al*., 2009).

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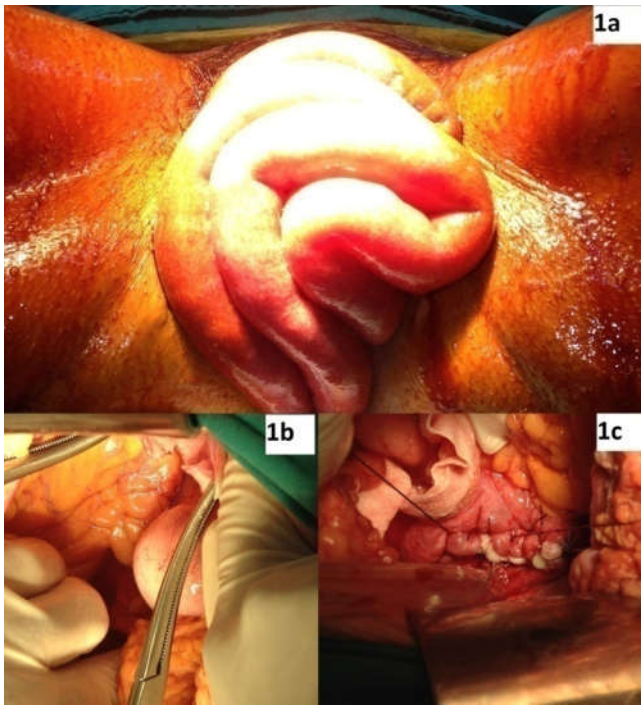

Fig. 1. Cuff dehiscence

The risk factors of VCD are: poor technique, postoperative infection, hematoma, coitus before healing, age, radiotherapy, corticosteroid therapy, trauma, previous aginoplasty, and use of the Valsalva maneuver (Somkuti *et al.,* 1994). Although, many women with VCD have no identify able precipitating event and spontaneous VCD has been reported up to 70% of cases as our case (Croak *et al*., 2004)

The incidence of VCD is reported in a retrospective study including 12, 398 patients after laparoscopic, abdominal, and vaginal hysterectomies 64%, 21% and 13%, respectively (Uccella *et al*., 2012). Evisceration occurs in up to 70%of VCD cases (Iaco *et al*., 2006). Still there is no accepted ideal method for VCD repair with or without evisceration. The surgeon must choose the technique which provide the best tissue approximation and strength of repair.

As a result VCD is a rare but serious complication that can be seen in any time after hysterectomy. Further investigations need for its prevention and ideal method of repair.

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