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Vaginal cuff dehiscence and evisceration 11 years after a radical hysterectomy: A case report

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ABSTRACT

INTRODUCTION: Vaginal cuff dehiscence (VCD) and evisceration (VCDE) are rare but rather serious complications of hysterectomy procedures.

We aimed to report a case of VCDE happening eleven years after the initial surgery and review a treatment protocol of this rare complication.

CASE: A 68 years old Tunisian female patient

In 2004, the patient underwent concomitant chemoradiation followed by total abdominal radical hysterectomy for a squamous cell carcinoma of the cervix.

Eleven years later, after an abdominal thrust due to a strong cough the patient had a protrusion of the two small bowels.

Patient was surgically treated following a combined approach.

The follow-up did not show any sign of relapse.

CONCLUSION: VCDE is a rare complication of hysterectomy that carries a lot of mobimortality if not treated on time.

Surgery without delay is usually a guarantee for a god outcome.

1. Introduction

Vaginal cuff dehiscence (VCD) and evisceration (VCDE) are rare but rather serious complication of any type of hysterectomy.

It's defined by partial or total separation of the vaginal cuff with the protrusion of intraabdominal content usually the small bowel [1].

Prolapse of the omentum, appendix and fallopian tubes have also been reported [2].

When it occurs, prompt surgical and medical intervention is required to ensure optimal care due to their high morbidity [3,4].

Throughout this study, we are reporting a case of VCDE which happened eleven years after the initial surgery. We are also reviewing the steps followed to manage this rare complication.

This work have been reported in line with the SCARE criteria [5].

2. Case presentation

A 68 years old Tunisian female patient treated for high blood pressure.

In 2004, the patient underwent concomitant chemoradiation followed by total abdominal radical hysterectomy for a squamous cell carcinoma of the cervix.

After four years,the patient underwent midline scar eventration repair using a polypropylene mesh.

No recurrence was observed during the follow-up.

Eleven years post-surgery,the patient was interned in our department for an abdominal thrust due to a strong cough the patient had a protrusion of two the small bowel.

During the physical examination, two protruding ileal segments with good vitality were found (Picture 1).

The manual reduction was not attempted since the full examination of the protruding ileum was not possible and because of the absence of bowel movements.

An abdominal X ray was made and showed several centrally located dilated gas loops filled bowel (Picture 2).

and the patient was made nil per os and immediately taken to the operating room with the bowel wrapped in a moist towel.

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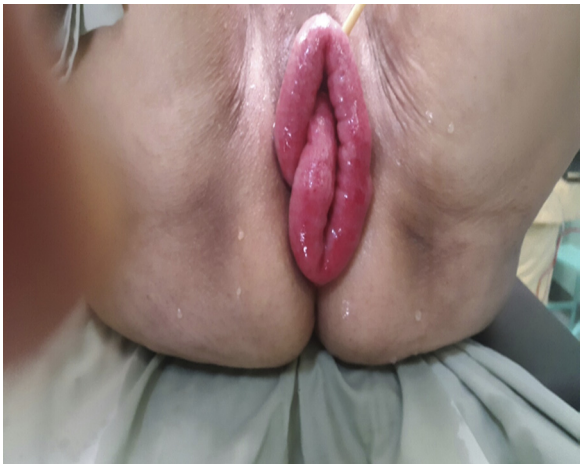
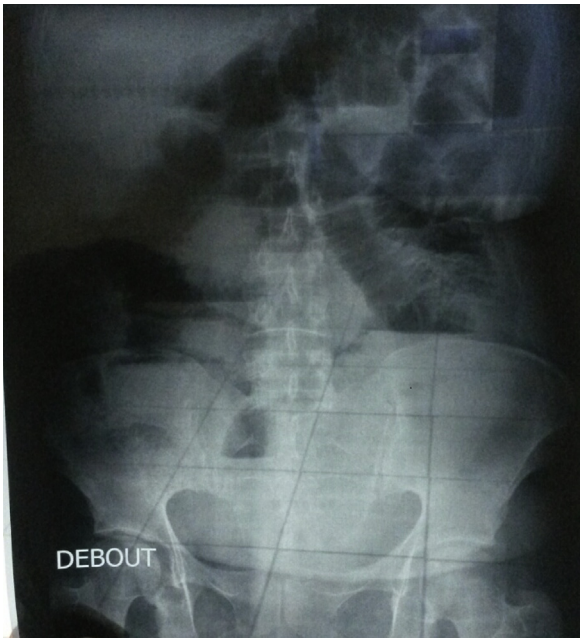


Picture 1. Vaginal evisceration of ileum segment.



Picture 2. Abdominal X ray showing dilated Gas filled bowel.

First we started with a midline incision, after the adhesiolysis no sign of recurrence were found. We found a 3 cm dehiscence of the vaginal cuff with the protrusion of two ileal segments.

We cautiously reduced the protrusing ileum reduced using a combined vaginal and abdominal approach. (Pictures 3 and 4)

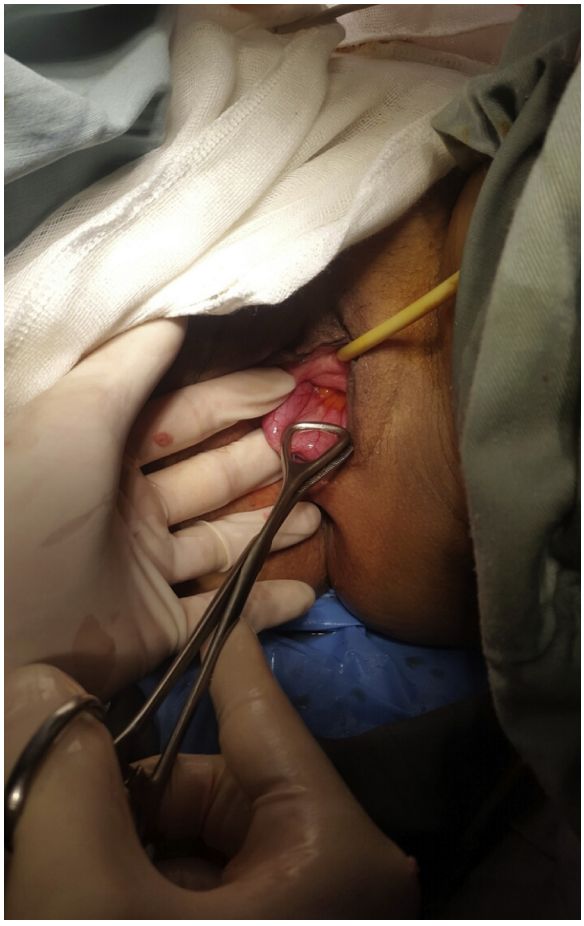
During the examination, we found a healthy ileum with no need for small bowel resection.

We closed the vagina with resorbable polyglactine 910 stitures. A polyglactine mesh was fixed above the vaginal cuff. (Pictures 4 and 5)

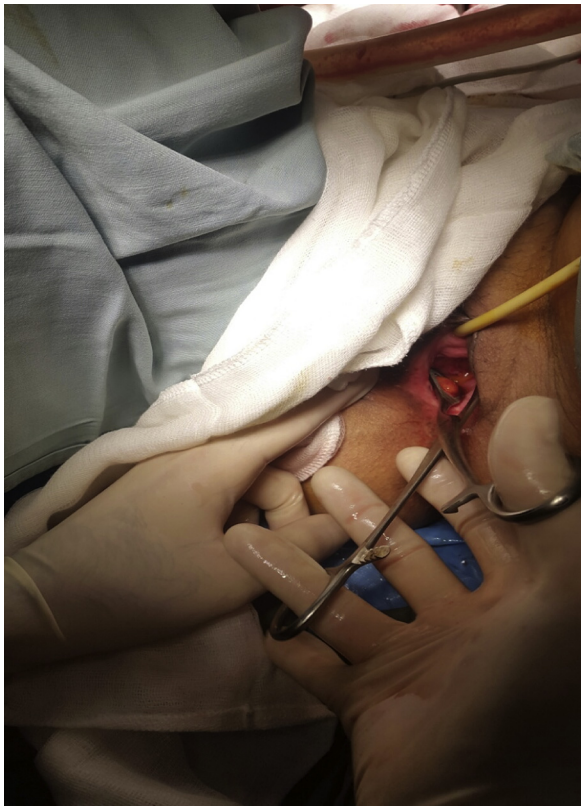
the patient was normal during the post-surgery follow up.

She recovered her bowel motility after 24 h, and she was discharged after 5 days with no need to major analgesic during her stay.

She was last seen three years post- surgery with no sign of recurrence.



Picture 3. Cautious reduction of the ileum with an atraumatic forceps.



Picture 4. Perineal view after Reduction.