VAGINAL EVISCERATION: A RARE COMPLICATION FOLLOWING RADICAL CYSTECTOMY IN FEMALE

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ABSTRACT
Large series on radical cystectomy in female are being reported with increasing frequency, but vaginal eversion does not attract attention as a significant long-term complication. We herein present a case with vaginal eversion and protrusion of intestinal loops per introitus, 8 months following radical cystectomy.

Keywords: Radical cystectomy, Female, Vaginal eversion

CASE REPORT
A 77-year-old woman presented to the emergency room with a mass, that she noted a few hours ago, protruding per introitus. On physical examination, anterior vaginal wall eversion was present and intestinal loops were observed to be protruding through the anterior vaginal wall (Fig.1). Her medical record revealed that she had undergone radical cystectomy and ureterosigmoidostomy 8 months ago for her bladder cancer. Her operation notes showed that anterior vaginal strip was removed with cystectomy specimen and vaginal flaps were closed continuously with polyglactin sutures after adequate hemostasis.
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Fig. 1: Intestinal segments protruding per introitus due to vaginal evisceration in a 77-year-old woman, 8 months after radical cystectomy. Note that intestinal loops are reddish and viable just prior to surgical exploration in the emergency room.

She immediately underwent surgical exploration in the emergency room, using a midline abdominal incision. Following the lysis of ileal adhesions, and after assessing the viability of intestinal segments, intestinal loops were reducted, and vaginal stump was repaired through the abdominal incision.

During her follow-up, perineal symptomatology has not recurred and she is cancer-free on her 4th postoperative year.

DISCUSSION

Since the vagina is highly vascularized, its dissection and reconstruction, performed by closing the vaginal flaps in a posterior-anterior plane with continuous polyglactin sutures, are among hardest steps of radical cystectomy in female and this may present a weak side of herniation as well as evisceration.

Vaginal evisceration and protrusion of intestinal segments per introitus has not been yet reported as a long-term complication in large radical cystectomy series. A few anecdotal cases have been reported to develop anterior enterocele, but not vaginal evisceration, following simple cystectomy for intractable interstitial cystitis, and they were all treated successfully with colpopexy. Probably, extensive mobilization of posterior vaginal wall during radical cystectomy and subsequent fibrosis prevent such complications. Furthermore, orthotopic neobladders present as a support to the anterior vaginal wall. Careful reconstruction of vaginal flaps with adequate support, and anterior colpopexy for those with non-orthotopic neobladders, can be considered as preventive measures against vaginal evisceration and subsequent protrusion of intestinal segments.

Vaginal evisceration is generally regarded to be a rare complication after vaginal surgery and as a complication of enterocele. Ileum is the most common viscus to herniate, however, omentum, salphinx, and epiploic appendices have also been described to protrude through the vaginal defect. Vaginal evisceration is often associated with pelvic support defect or previous vaginal surgery in postmenopausal women, and with obstetric or postcoital trauma and foreign bodies in younger women. Hypoestrogenism, atrophy and devascularization as a result of previous surgery, are considered to play significant roles.

Our case also had several risk factors for vaginal evisceration, other than pelvic surgery and technical factors, such as her postmenopausal age, history of multiple vaginal deliveries and thus poor pelvic floor support. Therefore, it must be kept in mind that, radical cystectomy, when performed in elderly female patients, carries the risk of vaginal evisceration due to hormonal status, poor pelvic floor support and technical reasons. Patients should also be informed about such a rare but serious complication in their follow-up. Treatment of vaginal evisceration is dependent on the nature and viability of the herniated structures. A combined abdominal and vaginal approach allows better assessment of the involved viscus and surrounding structures. Edema of the herniated viscus often makes spontaneous reduction back into the peritoneal cavity or mobilization out of the introitus impossible. Therefore, an abdominal approach is essential to sufficiently demarcate the extent of intestinal injury and provides the surgeon reliable information concerning the viability of intestinal segments prior to possible resection. This complication can thus be managed safely by reduction of intestinal segments if viable and by carefully repairing the vaginal defect through the abdominal incision.
REFERENCES


