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**Literature search results**

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**Search details**

Vault eversion following hysterectomy in adults. Laparoscopic versus abdominal surgical approaches.

**Resources searched**

NICE Evidence; TRIP Database; Cochrane Library; EMBASE; MEDLINE; Google Scholar

**Database search terms:** "vault eversion”; vault* adj2 (eviscerat* OR removal OR excis* OR exenterat* OR resect*); "vaginal vault”; vagina* adj2 vault adj3 (eviscerat* OR removal OR excis* OR exenterat* OR resect*); hysterectomy*; exp HYSTERECTOMY; laparoscop*; exp LAPAROSCOPY; (surgical OR surgery) adj2 (approach* OR technique* OR procedure*); (abdomen OR abdominal) adj2 (approach* OR technique* OR procedure*); exp SURGICAL PROCEDURES, OPERATIVE; (operative OR operation OR operations) adj2 (approach* OR technique* OR procedure*); (surgical OR surgery) adj2 (approach* OR technique* OR procedure*); (abdomen OR abdominal) adj2 (approach* OR technique* OR procedure*); (vault OR fornix OR fornic*) adj3 (eviscerat* OR removal OR excis* OR exenterat* OR resect*); (eviscerat* OR removal OR excis* OR exenterat* OR resect*)

**Evidence / Google Scholar search string(s):** "vaginal vault” (evisceration OR removal OR excision OR resection OR exenterate) hysterectomy / vault (evisceration OR removal OR excision OR resection OR exenterate) hysterectomy

**Summary**

There is some research on this topic; however it is limited when comparing the various
surgical approaches.

## Guidelines and Policy

None found.

## Evidence Reviews

None found.

## Published Research – Databases

1. **Vaginal evisceration repaired by sacrocolpopexy: A case report and mini-review of the literature**  
   **Author(s)** El-Tawab S.S., Nagati A.A.  
   **Citation:** Journal of Gynecologic Surgery, April 2014, vol./is. 30/2(105-107), 1042-4067:1557-7724 (01 Apr 2014)  
   **Publication Date:** April 2014  
   **Abstract:** When reviewing different reported cases of vaginal evisceration, wide variations among them become clear. These variations include menopausal status, hysterectomy or no hysterectomy, route of hysterectomy, its cause, interval between the surgery and evisceration, predisposing factors, and the treatment approaches. This case presentation and mini-review focuses on and blends these different parameters to help gynecologists be well-informed about the condition. **Case:** An 83-year-old woman was admitted to an emergency department. She had vaginal evisceration of a perforated loop of her small bowel. This occurred 20 years after this patient underwent a vaginal hysterectomy for a uterine prolapse. Through a midline incision, reduction of the small bowel loops was performed. The perforated vaginal vault was identified, as an 8-cm defect; then, the adherent bowel loops on the posterior vaginal wall (caused by the patient's long-lasting enterocele) were dissected carefully. Closure of the opened vaginal vault was accomplished in two layers, using absorbable sutures (polyglactin, Vicryl 1,<sup></sup> Ethicon, Johnson & Johnson). Then the closed vault was suspended through sacrocolpopexy, using a polypropylene mesh measuring 4x10acm. The small-bowel perforation was found 10acm from the ileocecal junction. After resection of 50acm of the prolapsed loops, including the perforated site, end-to-end anastomosis was performed. Finally, the patient was put in a lithotomy position to assess the need for any vaginal repair, and a posterior colporrhaphy was done. Results: This patient was returned to the ICU after full recovery. She received analgesia for 48 hours, total parenteral nutrition for 8 days, then a gradual oral diet was started. Her abdomen was lax, with no tenderness, and with well-heard peristalsis. The postoperative period was uneventful and this patient was discharged on the eleventh day postsurgery. She was followed up for 1 year with no complications or recurrence of the vault prolapse. **Conclusions:** Reported cases of vaginal evisceration vary in the literature, with no standardized method of repair. Sacrocolpopexy, using a polypropylene mesh, might be an ideal approach.  
   **Source:** EMBASE

2. **Laparoendoscopic single site (LESS) surgery in benign gynecology: Perioperative and late complications of 515 cases**  
   **Citation:** European Journal of Obstetrics Gynecology and Reproductive Biology, April
Objective: To present 515 LESS surgeries and report the perioperative outcomes and late complications according to the Clavien-Dindo classification. Study design: We performed a prospective single-center study (Canadian Task Force classification II-2). One surgeon trained in minimally invasive surgery performed 515 cases of LESS surgery from May 2008 to September 2011. Results: LESS gynecological surgery was performed on 515 patients (274 total hysterectomies; 26 subtotal hysterectomies; 87 adnexectomies including oophorectomy, salpingectomy, and salpingo-oophorectomy; 100 ovarian cystectomies; 17 myomectomies; 11 others). The median age and body mass index of the patients were 45 years and 22.6 kg/m², respectively. LESS surgery was successfully completed in 493 patients (95.7%) without the need for one or more ancillary ports or conversion to laparotomy. Twenty patients needed one or more additional ports and two cases were converted to laparotomy. One or more additional ports were required most frequently in ovarian cystectomy procedures (12/100, 12%). Thirty-six patients (7.0%) required intraoperative and/or postoperative transfusions. Each of these patients underwent hysterectomy (33/274, 12.0%) or subtotal hysterectomy (3/26, 11.5%). Perioperative complications (<30 postoperative days), excluding transfusions, occurred in 8 patients (1.6%) and included one case each of vault bleeding, vault abscess, stump watery discharge, rectal injury, and vesicovaginal fistula, and three cases of urinary tract injury. Late complications occurred in three patients (0.6%) and included two umbilical hernias and one vault evisceration. The overall complication rate, excluding transfusions, was 2.1% (11/515). Conclusion: The rate of late postoperative complications, including umbilical port site hernia and vault evisceration, was not increased in this study, as compared to previous reports of single-port and conventional laparoscopic surgeries. 2012 Elsevier Ireland Ltd.

Source: EMBASE

3. Robotic vault excision

Author(s) Puntambekar S.P., Puntambekar S.S., Desai R.Y., Galagali A.S.

Citation: Journal of Minimally Invasive Gynecology, November 2012, vol./is. 19/6 SUPPL. 1(S36), 1553-4650 (November-December 2012)

Publication Date: November 2012

Abstract: Introduction: With technological advances in minimal access surgeries, complicated procedures can be done with more precision and ease. In this video we present to you robotic excision of the vault for patient who was diagnosed as squamous cell carcinoma grade II after a vaginal hysterectomy. Method: The robotic ports remain same as that of pelvic robotic surgeries. Vaginal vault delineation is done with a sponge on a stick. This also helps to manipulate the vault. The robot is docked from in between the legs. Monopolar spatula and grasper are used. Result: Good vaginal margin and nodal clearance is achieved. Conclusion: With the benefits of magnification and 3D imaging, this difficult procedure can be done with a lot of precision robotically.

Source: EMBASE

4. Vaginal evisceration after hysterectomy: An increasing problem

Author(s) Onwere C.C., Bhattacharjee P.

Citation: International Journal of Gynecology and Obstetrics, October 2012, vol./is. 119/(S685), 0020-7292 (October 2012)

Publication Date: October 2012

Abstract: Objectives: To report a case of vaginal vault evisceration after hysterectomy and review the literature to identify increasing understanding of the risk factors, clinical presentation and treatment options of this gynecologic emergency. Materials: A 59-year-old woman treated for colon cancer and known metastases, presented to the emergency department with vaginal evisceration 6 years after vaginal hysterectomy for uterine prolapse. Approximately 15cm of the terminal ileum was irreducibly protruding through the vagina. Methods: The patient was transferred to the operating theatre. The prolapsed
bowel was reduced via the combined vaginal-abdominal route and the vaginal vault was closed with absorbable continuous sutures. Results: She was initially transferred to intensive care for the first 24 hours. She subsequently made an excellent recovery, with good colostomy function. Discharged day 2 post operatively. Conclusions: Highlight the increasing incidence of this rare but important post-operative complication and the necessity of a high degree of clinical suspicion for early diagnosis and management. Consideration is given to a possible association between this complication and laparoscopic hysterectomy procedures. Gynaecologists are challenged to incorporate this increased awareness and understanding of the condition into pre-operative counseling and on-going post-operative care and surveillance.

Source: EMBASE

5. Evisceration occurred 1 year after vaginal vault repair for relapsed pelvic organ prolapse.

Author(s) Muraoka M, Nagano H, Takagi K

Citation: Journal of Obstetrics & Gynaecology Research, July 2012, vol./is. 38/7(1028-31), 1341-8076;1447-0756 (2012 Jul)

Publication Date: July 2012

Abstract: This report describes the case of an 81-year-old woman with sudden evisceration of the small intestine through the vagina. It occurred one year after repair of a vaginal vault prolapse, which was initially treated by vaginal hysterectomy and colporrhaphy three years prior to the repair. On examination, we found a 70-80-cm loop of bowel prolapsing through a 3-cm oval defect in the vaginal vault. The patient underwent emergency exploratory laparotomy under general anesthesia. After careful reduction of the eviscerated small intestine, the hernia hiatus was closed and the widened cul-de-sac was obliterated by performing a Moschcowitz culdoplasty. Rapid intervention by abdominovaginal surgery may enable smooth repositioning of the eviscerated intestine, thus preventing subsequent morbidity. 2012 The Authors. Journal of Obstetrics and Gynaecology Research 2012 Japan Society of Obstetrics and Gynecology.

Source: Medline

Available in fulltext from Journal of Obstetrics & Gynaecology Research at EBSCOhost

6. Vaginal vault dehiscence after laparoscopic hysterectomy over a nine-year period at Sydney West Advanced Pelvic Surgery Unit - Our experiences and current understanding of vaginal vault dehiscence

Author(s) Chan W.S.W., Kong K.K.Y., Nikam Y.A., Merkur H.

Citation: Australian and New Zealand Journal of Obstetrics and Gynaecology, April 2012, vol./is. 52/2(121-127), 0004-8666;1479-828X (April 2012)

Publication Date: April 2012

Abstract: Background: A retrospective analysis of all women undergoing hysterectomy at Sydney West Advanced Pelvic Surgery Unit (SWAPS) was performed in the nine-year period from 2001 to 2009. Aims: To evaluate the incidence, timing and presenting symptoms of vaginal vault dehiscence after hysterectomy, especially via the laparoscopic approach to gain further understanding of patient risk factors and surgical factors that may predispose to this complication. Methods: Women who presented with vaginal vault dehiscence were identified and possible pre-operative, intra-operative and post-operative risk factors were assessed. A comprehensive literature search was performed to assess the current understanding and incidence of vault dehiscence after laparoscopic hysterectomy. Results: A total of 1224 hysterectomies were performed between 2001 and 2009. 989 (80.80%) were performed laparoscopically of which five women (0.42%) presented with vault dehiscence post-operatively. All had undergone total laparoscopic hysterectomy resulting in a vault dehiscence rate of 1.59% after total laparoscopic hysterectomy specifically. Baseline characteristics included a mean age of 42.8 years (37-51 years), mean BMI of 26.8 kg/m<sup>2</sup> (23.8-32.3 kg/m<sup>2</sup>) and a
mean parity of two deliveries (1-3 deliveries). The main presenting symptom of vaginal vault dehiscence was vaginal bleeding. Women with confirmed vaginal vault dehiscence readmitted to hospital at a mean of 18 days (11-28 days) post-operatively. Conclusion: Vaginal vault dehiscence is a rare complication after hysterectomy, but more common after a laparoscopic approach. A delayed presentation with vaginal bleeding was the main presenting symptom in this study - a literature review has shown common presenting symptoms to include abdominal pain, vaginal evisceration and vaginal bleeding. Techniques specific to total laparoscopic hysterectomy seem especially important in the increased risk of vaginal vault dehiscence seen after laparoscopic hysterectomy. 2012 The Authors. ANZJOG 2012 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Source: EMBASE
Available in fulltext from Australian & New Zealand Journal of Obstetrics & Gynaecology at EBSCOhost

7. Effectiveness of laparoscopic vaginal apex resection

Author(s) Ahluwalia P.K., Sikka S., Glantz J.C., Sugarman S., Schultz B.A.

Citation: Journal of Minimally Invasive Gynecology, November 2011, vol./is. 18/6 SUPPL. 1(S9-S10), 1553-4650 (November-December 2011)

Publication Date: November 2011

Abstract: Study Objective: To evaluate patient profiles and outcomes given posthysterectomy pelvic pain treated by laparoscopic vaginal apex resection (VAR). Design: This is a retrospective cohort study incorporating case note review and postal questionnaires. Mean time interval between VAR and sending out the patient questionnaire was 3.3 years with the longest follow up period being 11 years. Setting: St. Elizabeth Medical Center, Utica, NY and Little Falls Hospital, Little Falls, NY. Patients: We identified 27 consecutive patients who underwent laparoscopic vaginal vault excision for post-hysterectomy pelvic pain at our center from January 1998 to December 2009. Nineteen of 27 patient satisfaction questionnaires were returned. Intervention: At laparoscopy, full thickness vaginal vault excision was done, including treatment of any concomitant pathology. Questionnaires later were mailed to each patient regarding changes in pain scores pre/postoperatively with sexual intercourse, bowel movement, pelvic pain, back pain, urination, and overall physical and emotional health relating to symptoms prior to surgery. Measurements and Main Results: One-sample t-tests assessed changes in outcomes; linear regression was performed to adjust for possible confounding factors. Comparison of pain scores pre/post-surgery showed improvement associated with sexual intercourse, bowel movements, pelvic pain, back pain, urination, and overall condition (p<0.005). (Table presented) Of 8 patients unable to work before surgery due to pain, 7 reported returning to work after surgery. Patient satisfaction with the procedure was high, with 16/19 patients stating they would recommend this procedure to a friend with a similar condition. Neuroma was confirmed histopathologically in 55.5% of patients. Patients with neuroma had a non-significant trend towards improved overall response to surgery (p = 0.10). (Table presented) Conclusion: Vaginal apex resection is a safe and effective treatment option in selected patients with post-hysterectomy pain. It also provides the opportunity to evaluate other conditions that may contribute to pelvic pain. Although study size was small, the condition is common and often goes unrecognized.

Source: EMBASE

8. Vaginal vault dehiscence with evisceration after total laparoscopic hysterectomy

Author(s) Sinha R., Kadam P., Sundaram M., Mahajan C., Shah P., Lakhotia S., Rao G.

Citation: Gynecological Surgery, May 2011, vol./is. 8/2(175-176), 1613-2076;1613-2084 (May 2011)

Publication Date: May 2011
9. A small bowel prolapse through ruptured vaginal vault secondary to increased intra-abdominal pressure: A rare complication managed successfully through a multidisciplinary team approach

Author(s) Maatouk M., Smith S., Krishna K., Mathew V., Aff R.

Citation: American Journal of Case Reports, 2011, vol./is. 12/(118-121), 1941-5923 (2011)

Publication Date: 2011

Abstract: Background: Vaginal evisceration following a hysterectomy is a very rare condition and it was first reported in the literature in 1864. Small bowel is the commonest organ to prolapsed through a ruptured vaginal vault, presenting sometimes as an emergency condition that requires urgent intervention. Case Report: We report a case of an 86 year old female who presented to the emergency department with small bowel prolapsing through a ruptured vaginal vault, secondary to an acute exacerbation of her chronic cough by a recent chest infection. Following initial resuscitation, the small bowel was successfully reduced using ketamine for sedation. Vaginal repair, which is the definitive treatment, was carried out under spinal anaesthesia. The patient had an uneventful postoperative course; she was discharged home six days after surgery and remains well. Conclusions: The prolapse was managed successfully though a multidisciplinary team approach. Authors highlight the importance to manage rare and emergency presentations through multidisciplinary team. The American Journal of Case Reports, 2011.

Source: EMBASE

Available in fulltext from American Journal of Case Reports at Free Access Content
In 2009, a 41-year-old Thai woman who had undergone abdominal hysterectomy 4 months earlier was admitted because of bleeding per vagina without pain during coitus for 1 day. She had undergone pelvic examination that disclosed small intestine in vagina and scanty bleeding of vaginal vault. Closure of the rupture of the vaginal vault during laparotomy was completed, resulting in satisfactory condition. Vaginal vault rupture is a rare condition. Prompt surgical and medical intervention are required to prevent complications. Incidence, risk factors, and management for rupture of the vaginal vault that occurs after total abdominal hysterectomy are discussed.

**Source:** EMBASE

### 12. Laparoscopic Posthysterectomy Vaginal Vault Excision for Chronic Pelvic Pain and Deep Dyspareunia

**Author(s)** Trehan A.K., Sanaullah F.

**Citation:** Journal of Minimally Invasive Gynecology, May 2009, vol./is. 16/3(326-332), 1553-4650 (May/June 2009)

**Publication Date:** May 2009

**Abstract:** Study Objective: To evaluate the outcome of posthysterectomy laparoscopic vaginal vault excision and its long-term effects on chronic pelvic pain, dyspareunia, quality of life, and patient satisfaction. Materials and Methods: This is a retrospective cohort study (Canadian task force classification II-3) incorporating case note review and a postal questionnaire. It describes 22 consecutive patients who underwent laparoscopic vaginal vault excision for posthysterectomy dyspareunia and chronic pelvic pain. At laparoscopy, full thickness vaginal vault was excised along with scar tissue or any cyst. The vaginal cuff was closed laparoscopically. The patients were sent a validated questionnaire to assess their pain scores, general health, quality of life, and satisfaction with the surgery. The mean interval from vaginal vault excision and to questionnaire distribution was 1.8 years. The statistical analysis was performed with SPSS 15. Results: The mean age of the women was 40 years. All women had vaginal vault tenderness on examination and underwent laparoscopic vaginal vault excision. The only intraoperative complication was 1 puncture injury of the bladder, which was produced by 10-Veres needle during manipulation. A single or a combination of additional procedures was performed at the same time. The patient satisfaction questionnaires were received from 16 (72.7%) women. Of the 16 (72.7%) respondents, 13 (81.25%) confirmed improvement in dyspareunia. The mean pain scores decreased, and quality of life and general health improved significantly after vaginal vault excision (p <.05, t test). Conclusion: Laparoscopic vaginal apex excision is a safe and effective management option after carefully excluding other causes of deep dyspareunia and chronic pelvic pain. It also provides an opportunity to detect and surgically excise previously undiagnosed endometriosis and other disease. 2009 AAGL.

**Source:** EMBASE

### 13. Vaginal Vault Dehiscence after Hysterectomy

**Author(s)** Agdi M., Al-Ghafri W., Antolin R., Arrington J., O'Kelley K., Thomson A.J.M., Tulandi T.

**Citation:** Journal of Minimally Invasive Gynecology, May 2009, vol./is. 16/3(313-317), 1553-4650 (May/June 2009)

**Publication Date:** May 2009

**Abstract:** Study Objective: The purpose of our study was to evaluate factors predisposing vault dehiscence after hysterectomy and its manifestation. Design: Case series and review of the literature (Canadian Task Force classification II-3). Setting: Multicenter study. Patients: Retrospective analysis of 16 unpublished cases of vaginal vault dehiscence after total laparoscopic hysterectomy from physicians who participated in the exchange on the topic of vaginal vault dehiscence at the American Association of Gynecologic Laparoscopists Endo Exchange List (group A) and review of 38 reported cases in the
literature (group B). Interventions: The participating physicians were asked to complete a detailed questionnaire related to vault dehiscence. In addition, we performed literature search using the keywords "vault dehiscence," "vaginal vault dehiscence," "vault prolapse," and "hysterectomy," and conducted the search in MEDLINE, EMBASE, and Cochrane Database of Systematic Reviews. Measurements and Main Results: We estimated risk factors and characteristic features for vaginal vault dehiscence. The incidence of vault dehiscence was higher after laparoscopic hysterectomy (1.14%) than after abdominal hysterectomy (0.10%, p <.0001, OR 11.5) and after vaginal hysterectomy (0.14%, p <.001, OR 8.3). The time interval between hysterectomy and occurrence of vault dehiscence in the laparoscopic group (8.4 + 1.2 weeks) was significantly shorter than in the abdominal hysterectomy (112.7 + 75.1 weeks, p = .01) and in vaginal hysterectomy (136.5 + 32.2 weeks, p <.0001) groups, respectively. It appears that sexual intercourse was the main triggering event for vault dehiscence (58.8%). Vaginal bleeding (50%) and vaginal evisceration (48.1%) were the main symptoms. Conclusion: Our data suggest that vaginal vault dehiscence is rare but may occur more often after laparoscopic hysterectomy than after other hysterectomy approaches. Whether it is related to the technique of laparoscopic suturing is unclear. Other risk factors such as early resumption of regular activities and sexual intercourse may play a role. 2009 AAGL.

Source: EMBASE

14. Vaginal evisceration after hysterectomy: A rare condition a gynecologist should be familiar with

Author(s) Partсиневелос G.A., Родолакис A., Атанасиу S., Аntsакlis A.

Citation: Archives of Gynecology and Obstetrics, February 2009, vol./is. 279/2(267-270), 0932-0067 (February 2009)

Publication Date: February 2009

Abstract: Purpose: To report a case of vaginal vault rupture with intestinal herniation per vagina after hysterectomy and highlight the risk factors, clinical presentation and treatment options of this rare gynecologic emergency. Methods: A 70-year-old woman presented to the emergency department with vaginal evisceration, emerged 4 years after vaginal hysterectomy for uterine prolapse. Approximately 30 cm of the terminal ileum was irreducibly protruding through the vagina. Results: The patient was transferred to the operating theatre. The prolapsed bowel was reduced via the combined vaginal-abdominal route and the vaginal cuff was closed with non-absorbable interrupted sutures. Conclusion: Awareness as well as high suspicion index among gynecologists and all involved care givers, is important for early diagnosis, given that vaginal evisceration is a potentially life-threatening condition necessitating prompt surgical intervention. 2008 Springer-Verlag.

Source: EMBASE

Available in fulltext from Archives of Gynecology & Obstetrics at EBSCOhost

15. Abdominal sacrocolpopexy—standardized surgical technique, perioperative management and outcome in women with posthysterectomy vaginal vault prolapse.

Author(s) Huebner M, Krzonkalla M, Tunn R

Citation: Gynakologisch-Geburtshilfliche Rundschau, 2009, vol./is. 49/4(308-14), 1018-8843;1423-0011 (2009)

Publication Date: 2009

Abstract: AIMS: To provide a detailed description of abdominal sacrocolpopexy and to present a retrospective evaluation of the outcomes.METHODS: 78 patients underwent sacrocolpopexy between January 2004 and July 2006; 72% had concomitant procedures; 53 patients participated in the follow-up. Anatomical success was defined as any leading point of the vaginal wall remaining >1 cm above the hymen. Failures were split into 3 groups: (1) asymptomatic, no further treatment; (2) symptomatic, conservative treatment; (3) symptomatic, requiring repeat surgery. The key points of the surgical technique were standardized mesh shape, reasonable choice of fixation of the mesh to the anterior and
posterior vaginal walls as well as to the longitudinal ligament at S(2), and short operating
time.RESULTS: Standardization kept the mean operating time short (72.7 +/- 14.5 min for
sacrocolpopexy only, 86.4 +/- 21.0 min if combined with the Burch procedure; p = 0.03). At
the follow-up, none of the 53 patients (100%) presented with a recurrent apical prolapse;
17% (n = 9) had stage II anterior wall prolapse, and 69.8% (n = 37) did not show symptoms
specific to anterior wall prolapse. Regarding the posterior compartment, 38% (n = 20) had
stage II and 1 stage III posterior wall prolapse; 86.8% (n = 46) did not show symptoms
specific to posterior wall prolapse. Questionnaire items showed improvement of quality of
life. Nine patients required reinterventions: suburethral sling (3), excision due to erosion (2),
anterior (1) and posterior (1) repair, stapled transanal rectal resection (1), botulinum toxin
injection (1). Every fourth woman presented with symptoms requiring further
treatment.CONCLUSIONS: Sacrocolpopexy is a valid techniqu
on the pelvic retroperitoneum and parametrium.

Source: Medline

18. Bowel evisceration through the vaginal vault: A delayed complication following hysterectomy

Author(s) Patravali N., Kulkarni T.

Citation: Journal of Obstetrics and Gynaecology, 2007, vol./is. 27/2(211), 0144-3615;1364-6893 (2007)

Publication Date: 2007

Source: EMBASE

Available in fulltext from Journal of Obstetrics & Gynaecology at EBSCOhost


Author(s) Velchuru VR, Munasinghe N, Tou S, Preston J

Citation: Journal of Obstetrics & Gynaecology, November 2006, vol./is. 26/8(826-7), 0144-3615;0144-3615 (2006 Nov)

Publication Date: November 2006

Source: Medline

Available in fulltext from Journal of Obstetrics & Gynaecology at EBSCOhost

20. [Abdominal partial resection of the vagina and colpopexy: experiences with the procedure for posthysterectomy vault prolapse in 74 cases]. [Hungarian] Abdominalis colpopexia reszleges huvelyresectioval a posthysterectomias eversio gyogyitasara: 74 betegen vegzett mutet tapasztalata.

Author(s) Papp Z, Mezei G, Hidvegi J, Hupuczi P

Citation: Orvosi Hetilap, December 2005, vol./is. 146/52(2641-5), 0030-6002;0030-6002 (2005 Dec 25)

Publication Date: December 2005

Abstract: OBJECTIVE: To assess the abdominal partial resection of the vagina and infundibulopelvic colpopexy in women with posthysterectomy vaginal vault prolapse. OPERATIVE PROCEDURE AND MATERIAL: Slightly modifying the method described by Lampe, after laparotomy the elongated vaginal wall is resected and the vaginal vault is fixed by the sutures placed into the infundibulopelvic, sacrouterine, and round ligaments. The area is covered and elevated by the overlapping peritonaeum. During the last 15 years (July 1990 - July 2005) the procedure was offered and performed in 74 women because of vaginal eversion (aged 28 to 84 years; average age at operation was 58.5 years) after abdominal (24 cases) or vaginal (39 cases) hysterectomy or supravaginal amputation (4 cases) or abdominal colpopexy (7 cases). In 16 cases, anterior or posterior colporrhaphy were subsequently performed because of cystocele or rectocele or both.RESULTS: Perioperative complications included two bladder injury (2.6%), and transitory voiding difficulty in five cases (6.7%). There was neither bowel nor ureter injury. Patients were followed up annually by pelvic examination; in one of the 74 patients the vaginal eversion partly relapsed and the colpopexy was repeated. In one patient 18 months later because of intraabdominal adhesions a laparotomy and adhesiolysis was performed. All patients have a functional vagina without urinary incontinence and without pelvic pain or any pelvic discomfort.CONCLUSION: The abdominal partial resection of the vagina and colpopexy to the pelvic ligaments seems simpler than other techniques that are commonly used and a safe and reliable operation for the correction of posthysterectomy vault prolapse and
enterocele. A long term follow up is necessary to detect any late complications. The operation should be made only by gynecologists trained in the surgery of pelvic retroperitoneum.

Source: Medline

21. Vaginal evisceration after abdominal hysterectomy and vaginal brachytherapy

Author(s) Powell J.L., Meyerson M.B.

Citation: Journal of Pelvic Medicine and Surgery, 2003, vol./is. 9/3(125-128), 1077-2847 (2003)

Publication Date: 2003

Abstract: Background: Rupture of the vaginal vault followed by evisceration of bowel through the vagina is a rare complication after hysterectomy and an unforgettable experience for the physicians involved. Case: A 59-year-old white woman underwent abdominal hysterectomy, bilateral salpingo-oophorectomy, and pelvic and periaortic lymphadenectomy for endometrial adenocarcinoma International Federation of Gynecology and Obstetrics Stage IIA grade 3. Three high-dose-rate brachytherapy vaginal insertions with iridium were done 5, 6, and 7 weeks postoperatively. Thirteen days after the third insertion, she presented with a pinkish vaginal discharge, a 4-cm rupture in the vaginal vault, and small bowel loops prolapsed into the vagina. A vaginal repair was done. Conclusion: This is the first reported case of vaginal evisceration related to iatrogenic trauma at high-dose-rate brachytherapy insertion. Prompt surgical treatment can minimize complications.

Source: EMBASE

22. A case of transvaginal evisceration.

Author(s) Cerqui AJ, Haran M, Collier SM

Citation: Australian & New Zealand Journal of Obstetrics & Gynaecology, May 1998, vol./is. 38/2(229-31), 0004-8666;0004-8666 (1998 May)

Publication Date: May 1998

Abstract: We present a case of spontaneous evisceration of the small bowel through the vaginal vault in a 61-year-old women. The predisposing factors and management are discussed.

Source: Medline

23. Spontaneous vaginal vault rupture and evisceration 3 years post abdominal hysterectomy

Author(s) Oke O.O., Guirguis M., Rowley S., Grace R.H.

Citation: Journal of Obstetrics and Gynaecology, 1998, vol./is. 18/3(289), 0144-3615 (1998)

Publication Date: 1998

Source: EMBASE

Available in fulltext at Journal of Obstetrics and Gynaecology; Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.

24. Vaginal vault evisceration after total laparoscopic hysterectomy

Author(s) Nezhat C.H., Nezhat F., Seidman D.S., Nezhat C.

Citation: Obstetrics and Gynecology, 1996, vol./is. 87/5 II SUPPL.(868-870), 0029-7844 (1996)
Abstract: Background: Vaginal vault rupture with intestinal herniation, although rare, is a recognized postoperative complication of vaginal and abdominal hysterectomies. The incidence after laparoscopic hysterectomy is unknown. Cases: Three women, ages 40-43 years, presented to the emergency room with bleeding and pain 2-5 months after total laparoscopic hysterectomy. The small bowel was visible through the introitus or protruding into the vagina. Inspection of the bowel revealed no evidence of trauma. Two vaginal cuff repairs were completed transvaginally and one laparoscopically, all with interrupted sutures of no. 0 polydioxanone or polyglactin. In follow-up period of 12-17 months, the patients were doing well. Conclusion: Total laparoscopic hysterectomy may be associated with an increased risk of vaginal vault evisceration. Because laparoscopy increasingly is used to replace abdominal hysterectomy, it is important to be aware of this complication and its management.

Source: EMBASE

Available in fulltext from Obstetrics & Gynecology at the ULHT Library and Knowledge Services' eJournal collection

25. The surgical management of vaginal vault prolapse.

Author(s) Creighton SM, Stanton SL

Citation: British Journal of Obstetrics & Gynaecology, November 1991, vol./is. 98/11(1150-4), 0306-5456;0306-5456 (1991 Nov)

Publication Date: November 1991

Abstract: OBJECTIVE: A review of the results of surgery for vaginal vault prolapse following hysterectomy.DESIGN: A retrospective review of all patients treated surgically for vaginal vault prolapse between 1981 and 1990 in one hospital.SETTING: St George's Hospital, London.SUBJECTS: 28 women.INTERVENTIONS: The 28 patients underwent 33 operations, either a colposacropexy (23 procedures) or a Zacharin procedure (10 procedures). Of the 28 women 25 were seen in the gynaecological clinic within the last year.MAIN OUTCOME MEASURES: Pre- and post-operative data and any interim prolapse surgery was recorded. Success of the procedure in terms of cure, urinary complications, infection and sexual function.RESULTS: The mean follow-up time was 17.1 months for the colposacropexy and 33 months for the Zacharin. The cure rate for colposacropexy was 91% and that for the Zacharin procedure was 70%. The two commonest complications were development of a voiding difficulty and infection. Three women developed voiding difficulty following the Zacharin and one following colposacropexy. Two women following colposacropexy required removal of the Mersilene mesh due to a persistent discharging sinus.CONCLUSION: The colposacropexy had a better success rate and, as it is a simpler operation to perform, has become the operation of choice in this unit. It is, however, associated with a risk of infection which can necessitate removal of the supporting mesh.

Source: Medline

26. Massive evisceration: A complication following sacrospinous vaginal vault fixation

Author(s) Farrell S.A., Scotti R.J., Ostergard D.R., Bent A.

Citation: Obstetrics and Gynecology, 1991, vol./is. 78/3 II(560-562), 0029-7844 (1991)

Publication Date: 1991

Abstract: This report describes a spontaneous vaginal vault prolapse in association with massive evisceration following sacrospinous vaginal vault fixation. Careful attention to surgical technique is critical to the success of the operation. In particular, good apposition of the vaginal vault to the sacrospinous ligament and adequate repair of an enterocele should avoid this complication.

Source: EMBASE
Vaginal evisceration after hysterectomy: a literature review
PT Ramirez, DP Klemer - Obstetrical & gynecological survey, 2002 - journals.lww.com
... The typical complications of hysterectomy include bladder injury, ureteral injury, gastrointestinal injury, hemorrhage, postoperative fever, and vaginal vault prolapse. One rare complication of hysterectomy is evisceration of abdominal contents through the vagina. ...
Cited by 114 Related articles All 6 versions Cite Save

Vaginal evisceration following total laparoscopic hysterectomy: case report and review of the literature
CA Walsh, JRA Sherwin, M Slack - Australian and New Zealand ..., 2007 - Wiley Online Library
... among 7039 total hysterectomies for an incidence of 0.09% or almost one in 1000 hysterectomies. This study presented an additional four cases of vaginal vault dehiscence not complicated by evisceration, for an overall vault dehiscence rate following hysterectomy of 0.14%. ...
Cited by 22 Related articles All 4 versions Cite Save

Transvaginal evisceration after radical abdominal hysterectomy
SM Kim, HS Choi, JS Byun, YS Kim, HR Kim - Gynecologic oncology, 2002 - Elsevier
... 5; CH Nezhat, F Nezhat, DS Seidman, C Nezhat; Vaginal vault evisceration after total laparoscopic hysterectomy. Obstet Gynecol, 87 (1996), pp. 868–870. ...
Cited by 33 Related articles All 7 versions Cite Save

[HTML] Vaginal cuff dehiscence after robotic total laparoscopic hysterectomy
... 2002]; Incidence and patient characteristics of vaginal cuff dehiscence after different modes of hysterectomies. J Minim Invasive Gynecol. 2007 May-Jun; 14(3):311-7. [J Minim Invasive Gynecol. 2007]; Vaginal vault evisceration after total laparoscopic hysterectomy. ...
Cited by 39 Related articles All 5 versions Cite Save

Vaginal evisceration after hysterectomy: the repair by a laparoscopic and vaginal approach with a omental flap
F Narducci, Y Sonoda, E Lambaudie, E Leblanc... - Gynecologic ..., 2003 - Elsevier
... Vaginal evisceration after hysterectomy is a surgical emergency. ... After resection of the top of the vagina, we decided to resuture it with a more important omental flap reinforced by a mesh (Vypor° II, polypropylene ... Vaginal vault evisceration after total laparoscopic hysterectomy. ...
Cited by 38 Related articles All 5 versions Cite Save

Transvaginal evisceration of small bowel after radical hysterectomy and pelvic lymphadenectomy
B Dawlatly, O Lavie, A Lopes - Gynecologic oncology, 1999 - Elsevier
... She was treated by laparotomy and resection anastamosis of a discolored part of the distal ... A segment of distal ileum was found prolapsing through the vaginal vault and this was ... In this case evisceration appears to have resulted from excessive and prolonged straining during ...
# Published Research – Database Search Strategy

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