PRIMARY ENTEROCELE

(A Case Report)

by

N. B. SWAMI*, M.D.

RAJNI B. VYAS**, M.D., D.G.O.

Enterocele or herniation through the cul-de-sac of Douglas is described under various names as posterior vaginal hernia, rectovaginal hernia, cul-de-sac hernia or Douglas's pouch hernia. Though known rarely as high rectocele it is a misnomer.

Enterocele is quite commonly seen in association with cystocele, rectocele and uterine prolapse. But existing alone, it is a clinical curiosity. The case presented as primary enterocele had trophic ulcers on the exposed part without perineal laxity or prolapse of uterus.

Case Report

Mrs. N. A., aged 60 years, was admitted on 21-4-'66 for post-menopausal bleeding per vaginam for the last 5 months and something coming out per vaginam for two years. There was no history of difficulty in micturition or defaecation.

Onset of menopause was 9 years ago. She had 8 F.T.N.D. conducted at home. Last delivery was 18 years ago. On examination, patient was fairly well built and nourished. B.P. was 110/60 mm. of Hg. Screening of the chest was normal. Haemoglobin was 9 gms% and stool showed ova of ankylostoma.

*Antenatal Officer, S. S. G. Hospital, Baroda.

**Lecturer in Obstetrics & Gynaecology, Medical College, Baroda.

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On examination, a big mass protruding out of the vagina with two trophic ulcers was seen. It was confirmed to be a big enterocele by vaginal examination. Cervix was small and healthy, uterus was retroverted retroflexed, small and atrophic. Fornices were clear. Biopsy report from ulcers, cervix and endometrium showed no evidence of malignancy. Diagnosis of enterocele was confirmed by rectal examination to differentiate it from rectocele.

Vaginal repair was done. The dissection of sac with high transfixion was carried out. The uterosacral ligaments were approximated in their entire length by interrupted sutures followed by pelvic floor repair. The patient was examined, six months later and had no evidence of recurrence.

Discussion

Enterocele can be congenital or acquired. In the congenital variety, a deep cul-de-sac acts as a wedge where the space between anterior wall of rectum and posterior vaginal wall is dissected downward to form a hernial sac. It forms a narrow sac just behind the cervix between the uterosacral ligaments. It lies on top of the anterior wall of rectum and behind the posterior wall of vagina in the rectovaginal septum.

In the acquired type, a deep cul-de-sac might already exist, but childbirth may be a precipitating factor, either by tearing or stretching of the

rectovaginal fascia. The descent of uterus results in an elongation of the cul-de-sac and raised intra-abdominal pressure carries it downward. A second type follows a total or subtotal hysterectomy or suspension or fixation operation for prolapse.

The establishment of diagnosis and differentiation from rectocele is a key point to its cure. A bulge in the posterior fornix high up is diagnostic. A finger inserted in the rectum will demonstrate a rectocele and absence of continuity with the bulge high up in the fornix establishes the diagnosis of enterocele.

There are three accepted methods of surgically treating the patient. The abdominal method is obliteration of a deep cul-de-sac by purse-string sutures one above the other. It was described by Moschovitz (1942). The vaginal method was described by George Gray Ward (1929). The principle of the operation is isolation and closure of the sac as high as possible and closure of defect through which the sac leaves the abdomen. This method was adopted in the present case. Colpocleisis is the method for large hernias where laparotomy is contraindicated.

Summary

A case of primary enterocele with trophic ulcers is reported. Review of literature on aetiology, types and treatment is discussed.

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Fig. on Art Paper IV