A CASE REPORT OF RUPTURED ENTEROCOELE WITH PROLAPSED INTESTINES

by

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Visualising a loop of bowel protruding through the vagina is an alarming and unforgettable experience for both the patient and the gynaecologist. Because of its rarity, such an interesting case is reported here.

CASE REPORT

Gangamma aged 55 years was admitted to Chigateri General Hospital, Davangere on 13th of June 1981 at 3-30 P.M. with the intestines protruding out of the introitus since 2 hours following an injury caused by a Cow's Horn. She had remained unconscious for few minutes following the injury. There was no complaint of bleeding P/V.

She had two full term Normal deliveries at home the last delivery being 30 years back. An year after the first delivery i.e. 35 years back, she had noticed the Mass P/V for which she had not consulted any Doctor. She had attained menopause 10 years back.

General examination showed that she was anaemic, apprehensive Temp. N Pulse rate 64/M good volume B.P. 140/100 mm of Hg. CVS RS & P/A—NAD.

Genital examination revealed about 3 feet of loops of small intestines with the mesentary pink and slightly edematous protruding through the introitus. There was no bleeding from the vagina.

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One and half hour after the admission, Patient was taken for laparotomy with the assistance of a Surgeon. Under G.A. abdomen was opened by a subumbilical midline incision. The exposed intestines were reduced into the abdominal cavity. While reducing a tear occurred in the mensentery about 2″ from the junction of ileum and jejunum and was sutured. Another contusion of the mesentery found at the junction of the ileum and jejunum was also sutured. The prolapsed intestines were tested for viability after clamping by application of hot packs and continuous oxygen administration for 3 minutes. Return of pink colour and peristalsis were observed. A transverse rent in the pouch of douglas which was about 3″ was closed with continuous sutures. Abdomen was closed in layers after perfect hemostasis. On P/S examination there was a stellate shaped tear in the middle of the posterior vaginal wall which was closed with interrupted sutures. Cervix was healthy. The tear in the pouch of douglas and that in the vagina were not in the same plane. She was discharged on 24th day with an advice to come after 3 months for repair operation. She had procidentia with an atrophic uterus.

Discussion

Review of literature gives data of cases of rupture of an enterocoele followed by eviseration of bowel through the vagina-though fortunately it is rare. Spontaneous as well as traumatic rupture of vagina have been reported. Majority of the cases reported in the literature are the result of a spontaneous rupture of a recur-

rent enterocoele months or years following vaginal operation. Rolf (1970) described instance of ruptured enterocoele with prolapsed bowel. Hunter *et al* (1970) have described a patient with ruptured enterocoele and have summarised data collected from previous records of 15 patients published between 1909-1970.

Most of the cases reported have occurred in postmenopausal women whose atrophic tissues were scarred and poor in quantity. A thin vaginal wall due to postmenopausal atrophy is vulnerable to traumatic penetration.

The longitudinal direction of vaginal tear in cases of cow or bull's injuries indicates the commencement of trauma from below inwards. Its final direction whether anterior, central or posterior determines whether anterior vaginal wall with bladder or posterior fornix or posterior vaginal wall with rectum are injured. The obliquity of vaginal wall and longer length of the posterior vaginal wall are likely factors in such injuries.

A complication as serious as this would be expected to result in a high mortality rate. However, the patients reported have survived in many instances. Presence of bowel protrusion for nearly 48-72 hrs. without the patient becoming septic or severaly shocked have been reported. The absence of post operative sepsis and prolonged ileus represent the ability of the peritoneum to withstand a single insult of contamination.

Apart from primary suturing, use of antibiotics, thorough wash of prolapsed intestines with saline, stretching of the constriction ring if necessary, the additional measure required is further observation to rule out bowel injury, Fox *et al* (1971) described a patient with ruptured enterocoele with prolapsed intestines. The opening in the upper post vaginal wall through which the intestines protruded was enlarged by stretching and intestines were replaced into the abdominal cavity. The peritoneal opening of the enterocoele was closed with pursestring suture of chromic catgut, and vaginal wall closed with interrupted chromic catgut.

In our case it was decided to reduce the intestines after opening the abdomen, lest any bowel injury be missed as a longer portion of the intestines had prolapsed.

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See Fig. on Art Paper III