

## Prolapsed uterus with huge rectocele and omentocele following cervical amputation: A rare and unusual case presentation

Pokharel H<sup>1</sup>, Banerjee B<sup>2</sup>, Koirala R<sup>3</sup>

<sup>1</sup>Assistant Professor, <sup>2</sup>Professor, <sup>3</sup>Junior Resident, Department of Obstetrics and Gynaecology, BP Koirala Institute of Health Sciences, Dharan, Nepal

---

### Abstract

Pelvic organ prolapse is a common condition whose incidence is increasing. Many cases of prolapse of the posterior vaginal wall occur along with other pelvic support defects. Pelvic surgeons who treat rectocele must have an excellent understanding of the normal anatomy, interactions of the connective tissue and muscular supports of the pelvic, and the relationship between anatomy and function. Pelvic pressure, the need to splint the perineum to defecate, impaired sexual relations, difficult defecation, and faecal incontinence are some of the symptoms that have been described in patients with rectocele.

**Key words:** Rectocele, fothergills operation, utero- vaginal prolapse.

---

**R**ectocele and other forms of pelvic organ prolapse are the result of women attaining an erect bipedal posture. Etiologically, most cases are the result of vaginal childbirth and chronic increases in intra-abdominal pressure. In some patients, rectocele is thought to develop as a result of congenital or inherited weaknesses within the pelvic support system.

A number of iatrogenic factors may contribute to pelvic organ prolapse, including failure to adequately correct all pelvic support defects during surgery. In some patients, the failure to reattach the endopelvic fascia to the perineal body at the time of vaginal delivery leads to a site-specific defect in the endopelvic fascia. Additionally, procedures that alter the direction of pelvic forces can cause areas to be prolapsed that previously had been adequately supported.

Examples include:

1. Ventral suspensions of the urethra, uterus, or vagina that increase exposure of the cul-de-sac to increases in intra-abdominal pressure.
2. Posterior fixation of the vaginal apex
3. Failure to detect and correct an occult enterocele.
4. Excessive shortening of the vagina.

### Case Report

A physically challenged (Deaf and Dumb) residing in Bihar was admitted in Gynae Ward of BPKIHS on 06/12/22 with complain of mass coming out per vaginum since 6 years, wound over the mass since 1

month, bleeding occurred per urethra during cycles. Patient had not visited any other hospitals in this regard.

Mass was initially small and was gradually increasing in size, gets reduced on reposition.

Her menstrual history is regular with normal flow but patient noted the menstrual flow was very near to the urethra. LMP 2/12/061.

### Obstetric history

P<sub>2</sub>L<sub>2</sub>. First son is 27 yrs. FTNVD at Rajbiraj Hospital labour pain lasted for 13 hours. She resumed her work 20 days postpartum. Second son is 25 yrs, FTNVD at Saharsa Hospital. Labour pain lasted for 4 hours. There was a h/o urinary retention at 4 months. POG, following which ring pessary was kept, which was removed 10 days prior to delivery. Pessary was not changed for 6 months? Cervical amputation (Records not available) with tubal ligation was done on 6<sup>th</sup> postpartum day at Saharsa Hospital. Family and Personal history were not significant.

---

### Correspondence

Dr. Hanoon Pokharel  
Assistant Professor,  
Department of Obstetrics & Gynecology,  
BP Koirala Institute of Health Sciences, Dharan, Nepal

On physical examination, vitals were stable. Local examination revealed. Dry vaginal epithelium, cervical os not seen, cervix flushed with vagina, Decubitus ulcer on posterior side huge rectocele and mild cystocele. PV – procidentia, ut RV pre-operatively Haemoglobin 5gm/dl for which she received 1 unit of blood transfusion. Surgery was performed on 06/12/25 after complete investigations.

***Intra op findings***

Cervix was not seen, but lower part of body of uterus was dissected out with taking care of the ureter.

Subsequently huge rectocele with omentocele was explored and repaired after taking out redundant portion. During repair there was injury to the lower part of the rectum (3X2.5cm) which was repaired.

This was almost unavoidable because it was only separated by rectal fascia. Surgery performed was vaginal hysterectomy with pelvic floor repair with repairs of rectal injury. Post operative period was uneventful and patient was discharged on the 8<sup>th</sup> day in good condition. She is on follow up in Gynae OPD and found to have better quality of life.

**Fig. 1: Decubitus ulcer and rectocele**



**Fig. 2: Amputated cervix)**



**Fig. 3:** Urethral opening with foley's catheter



### **Discussion**

Rectocele is a defect of the rectovaginal septum not the rectum. The pelvic surgeon must know the anatomy of the pelvic floor and the other supports of the pelvic floor and the other supports of the vagina in order to diagnose and treat this disorder<sup>1,2,3</sup>.

The muscular support of the pelvis is from the pelvic diaphragm. The pelvic diaphragm is made up of a group of paired muscles that include the levator ani and coccygeus muscles. The levator ani are composed of the puborectalis, pubococcygeus, and ileococcygeus muscles. These muscles have their origin at the pubic rami on either side of the midline at the level of the arcus tendineus levator ani<sup>3,4</sup>. The muscle fibres of the levator ani pass lateral to the vagina and rectum, creating a sling surrounding the genital hiatus. They also create the pelvic floor posteriorly and laterally. When a woman contracts the levator ani, the pelvic diaphragm provides a horizontal shelf where the pelvic viscera lie and the genital hiatus closes<sup>2,5,7</sup>.

The perineal body is located between the vaginal introitus and anus. It is the attachment for the perineal membrane (bulbocavernosus muscles, superficial transverse perineal muscles and investing fascia), a portion of the levator ani, the external anal sphincter, and the rectovaginal (endopelvic) fascia<sup>4,6,8</sup>. Through its attachment to the cardinal and uterosacral ligaments, the rectovaginal septum stabilizes the perineal body, which is essentially suspended from the sacrum. The perineal body is further stabilized through the lateral attachments of the perineal membrane to the ischiopubic rami. Between the lateral and superior support, the downward mobility of the perineal body is limited.

However, if this attachment is separated, as can occur during childbirth, the perineal body can become more mobile, leading to rectocele and perineal descent<sup>8</sup>.

### **Clinical Manifestations**

Patients with rectocele often present with feelings of pelvic pressure, a sensation of "bearing-down," or a perception that something is "falling out." Symptoms are often accentuated by standing and lifting and relieved by lying down. Symptoms directly related to the prolapse include the sensation of a mass or bulge in the vagina, pelvic pressure and pain, low back pain, and difficulty with intravaginal intercourse. Symptoms directly related to rectocele include defecatory dysfunction, inability to completely evacuate the distal rectum without straining, constipation, and dyspareunia.

### **Relevant Anatomy**

The pelvic organs are maintained within the bony pelvis by levator ani muscles that are posteriorly fused (pelvic floor). The levator ani muscles are attached to the bony pelvis anteriorly and posteriorly; laterally, they are attached to arcus tendineus musculi levatoris ani.

The perineal body is a central point for the attachment of the perineal musculature. The perineal body lies beneath and supports the pelvic diaphragm. Although the contents of the abdominal cavity bear down on the pelvic organs, they remain suspended in their relation to each other and to the underlying levator sling and perineal body. Each organ is capable of independent function because it is separated from other organs by connective tissue spaces within the endopelvic connective-tissue support system. The normal tonic contraction of the

levator ani muscles supports the pelvic organs from below and contributes to urinary and faecal continence. Relaxation of the levator ani muscles allows descent of the pelvic organs and aids urination and defecation.

### ***Laboratory Support***

Usually necessary in uncomplicated cases; however document Papanicolaou test (pap smear) cytology.

### ***Medical Therapy***

Non surgical and surgical methods are available for treating symptomatic patients. Generally, treatment is determined by the age of the patient, the desire for future fertility, the desire for coital function, the severity of symptoms, the degree of disability, and the presence of medical complications. One responsibility of the physician is to inform women of their treatment options and the potential benefits and risks of each option. Medical treatment options for women with symptoms primarily consists of management with pessaries.

### ***Prophylactic measures***

Patients can be treated successfully with a pessary for years. In spite of this one should consider for surgery when there is need for definitive surgical correction, recurrent vaginal ulcerations due to pessary use, or genuine stress incontinence that the patient deems unacceptable. Prophylactic measures for preventing rectocele include diagnosis and treatment of chronic respiratory and metabolic disorders, correction of constipation and intra-abdominal disorders that may cause chronic increases in intra-abdominal pressure, and administration of estrogen to menopausal women who have no contraindication to its use.

Counsel patients about the preventive effects of weight control, proper nutrition, smoking cessation, and avoidance of strenuous occupational and recreational stresses that could damage the pelvic support system. Teach and encourage women to perform pelvic muscle exercises as a method of strengthening their pelvic diaphragm and as prophylaxis against the development of rectocele. Failure to recognize and treat significant support defects at the time of concomitant gynaecologic surgery can lead to progression of rectocele.

Similarly, opening up the genital hiatus by performing a retropubic urethropexy (e.g., Buurch procedure) can predispose a patient to enterocele and rectocele. Disabilities that may occur include inability to defecate without manual replacement of the uterus, bladder, or rectum; sexual dysfunction; and vaginal ulceration. For mild degrees of

relaxation, especially in younger women immediately following childbirth, levator muscle exercises, sometimes called Kegel exercises, are helpful in restoring the tone of the muscles of the pelvic floor. Instruct patients how to appropriately contract the puborectalis muscles. Patients should repeat this exercise approximately 75 times during the day. Like most forms of physical therapy, this is usually more effective in premenopausal women than in older women, in whom generalized skeletal muscle atrophy has occurred. With minor degrees of pelvic relaxation, estrogenic hormones may help improve the condition of the vaginal mucous membrane and relieve minor symptomatology.

Numerous vaginal pessaries are available that are designed to support specific types of pelvic organ prolapse. On occasion, the vagina and its outlet may be so dilated that it does not hold a pessary. If no other reasonable therapeutic option is available for such a patient, a perineorrhaphy can be performed with the patient under local anaesthesia, thus constricting the vaginal outlet to enable it to retain a pessary.

Pessaries can cause vaginal irritation and ulceration. They are better tolerated when the vaginal epithelium is well estrogenized, making exogenous estrogen essential in the hypoestrogenic patient. Remove, clean and reinsert vaginal pessaries periodically; failure to do so can result in serious consequences, including fistula formation.

### ***Conclusion***

This case made us to observe that during Fothergill Procedure, Operating surgeon need to be cautious to open the Pouch of Douglas and tie the Utero Sacral Ligaments to avoid such complication. The cases done in such method are not seen with complication like this in our experiences so far.

### ***References***

1. Vault prolapse and rectocele : assessment of repair using sacrocolpopexy with mesh interposition. Fox AD, Stanton SL .Br J Obs Gyn 107(11):1371-1375. Nov 2000
2. American college of obstetricians and gynaecologists: Pelvic organ prolapse. In: ACOG Technical Bulletin 214. Washington, DC: ACOG 1995.
3. Cundiff CW, Fenner D: Evaluation and Treatment of women with rectocele: Obstet Gynecol 2004 Dec; 104(6):1403-2
4. DeLancey JO: Anatomic aspects of vaginal eversion after hysterectomy. Am J Obstet Gynecol 1992 June; 166:1717-24.

5. Nichols DH: Posterior Colporrhaphy and perineorrhaphy: Separate and distinct operations. Am J Obstet Gynecol 1991 Mar; 164(3): 714-21.
6. Williams obstetrics .21st Edition.F.Gary Cunningham et al.
7. Novak's Gynecology.12th Edition.Jonathan S.Berek et al.
8. Te Linde's operative gynecology .8<sup>th</sup> Edition.John A Rock et al.