Letter

A Rare Case of Spontaneous Transvaginal Intestinal Evisceration

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To the Editor

Transvaginal intestinal evisceration is a rare surgical emergency, complicated by bowel ischemia, ileus and peritonitis. It was first reported in 1864 by Hyernaux [1] and then by McGregor in 1907 [2]. It is very rare and fewer than 150 cases have been described worldwide [3,4]. It can occur more often in elderly postmenopausal women than in younger women [5,6]. Bowel evisceration is a complication of gynecologic surgery, typically arising in conjunction with trauma or conditions heightening intra-abdominal pressure. The clinical presentation is that of intestinal obstruction due to bowel herniation through the vagina.

A 55-year-old woman presented to the Department of Accident and Emergency for abdominal pain and transvaginal intestinal evisceration. She reported a previous diagnosis of ovarian cancer five years before, treated with laparoscopic bilateral hystero - oophorectomy and chemotherapy. Histological diagnosis was Epithelial Ovarian Carcinoma. During hospitalization, laboratory exams were conducted with the following results: leukocytosis ($13.0 \times 10^3/\mu L$), increased C-reactive protein (CRP) (300 mg/L), and hyperlactatemia (lactate 4.1 mmol/L). Computed tomography (CT) scan (Fig. 1A,B) showed reduced blood flow in the eviscerated intestinal loop. The eviscerated intestine, appearing edematous, thickened, and discolored (Fig. 2A), was wrapped with warm sterile saline-soaked gauze. The patient received intravenous broad-spectrum antibiotics, including cefazolin and metronidazole, together with intravenous fluid therapy, and was taken to the operating room. After induction of general anesthesia, manual reduction of the eviscerated bowel was performed through the vagina, and vaginal packing with gauze was placed to prevent recurrent intestinal prolapse. Surgical intervention started with a midline incision. Abdominal exploration revealed purulent contamination of the abdominal cavity and a laceration of the vaginal cuff (Fig. 2B). The vaginal cuff was identified and repaired with 2-0 Vicryl sutures. After aspiration of the contaminated fluid and abdominal lavage with warm saline, careful inspection revealed a 50 cm segment of edematous and ischemic ileum. The affected segment was resected using an Echelon 45 stapler. Because the distance from the ileocecal valve was approximately 70 cm, a terminal ileostomy was created, and an abdominal drain was placed. The postoperative course was uneventful. On postoperative day (POD) 1, the stoma passed flatus, the nasogastric tube was removed, and the patient started drinking water. A solid diet was started on POD 2. The patient was discharged on POD 4.

Transvaginal intestinal evisceration is a rare but life-threatening surgical emergency, with only a limited number of cases reported in the literature. Kowalski et al. [4] reviewed 60 cases published since 1901, the majority of which occurred in postmenopausal women. A characteristic triad consisting of previous vaginal surgery (73%), postmenopausal status (68%), and the presence of an enterocele (63%) was identified as a recurrent predisposing pattern. Postmenopausal status is considered a major risk factor, likely related to hypoestrogenism-induced vaginal wall atrophy, reduced tissue elasticity, and progressive pelvic floor weakness [7,8,9].

Similarly, Croak et al. [10] reported that 9 of 12 cases of vaginal rupture were associated with postmenopausal pelvic organ prolapse and a history of pelvic surgery. Notably, women who had undergone abdominal hysterectomy most commonly experienced rupture at the level of the vaginal cuff, whereas those with a history of vaginal hysterectomy tended to rupture through a posterior enterocele. These findings are consistent with the clinical background of our patient and support the role of prior pelvic surgery as a key contributing factor.

The present case is clinically relevant because it illustrates that transvaginal bowel evisceration may occur not only in elderly women with advanced pelvic floor disorders, but also in relatively younger postmenopausal patients with a history of oncologic pelvic surgery. In our patient, prior laparoscopic hystero-oophorectomy, tissue fragility, and delayed tissue failure at the vaginal cuff likely acted syner-

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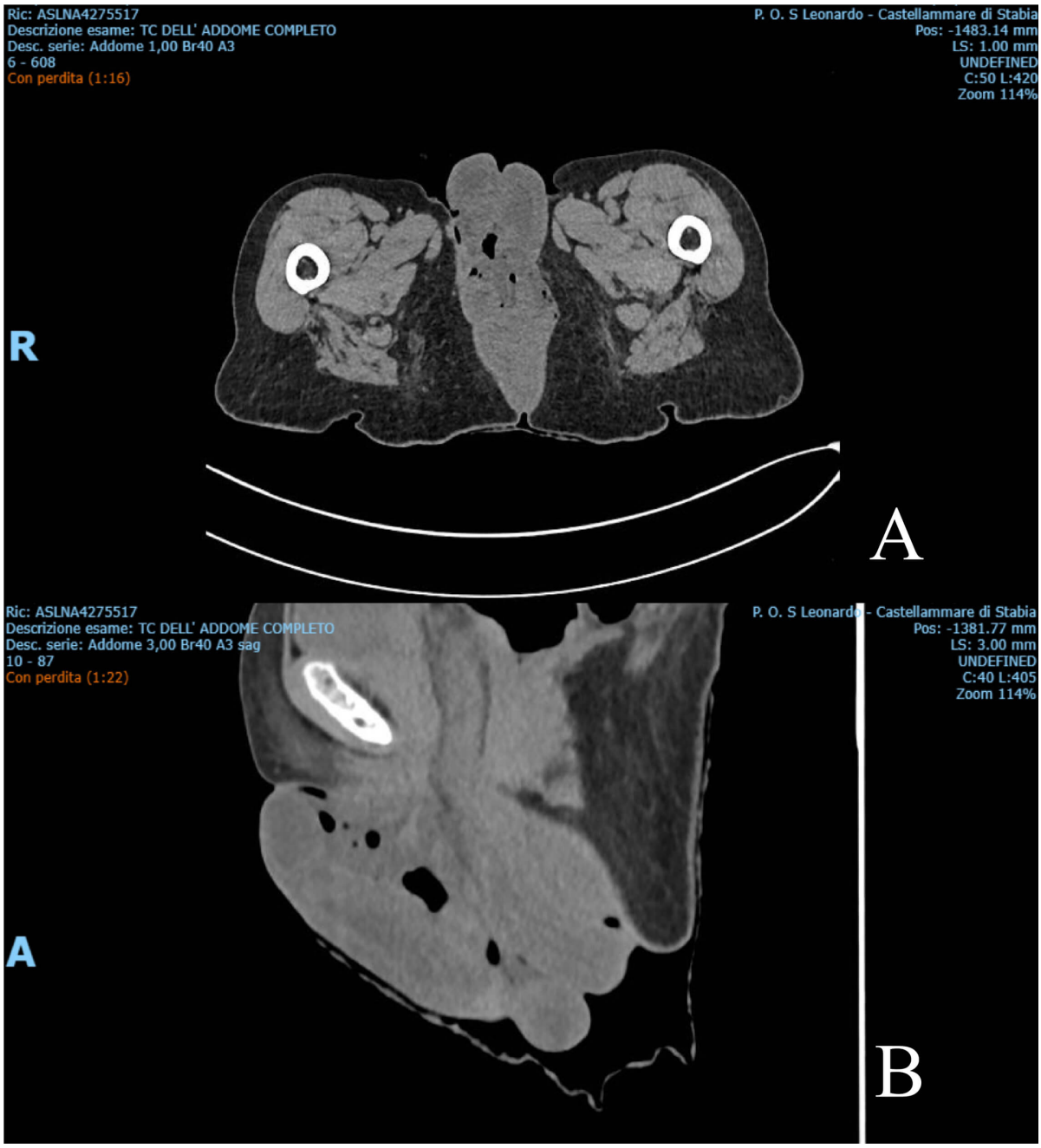

Fig. 1. Contrast-enhanced computed tomography showing transvaginal herniation of small bowel loops. (A) Axial view demonstrating herniation of edematous small bowel through the vaginal canal. (B) Sagittal reconstruction confirming transvaginal protrusion of small bowel loops beyond the vaginal introitus.

gistically. Unlike many reported cases managed without bowel resection, this patient already showed intestinal ischemia and purulent intra-abdominal contamination at presentation, requiring ileal resection and terminal ileostomy. This highlights the importance of early recognition, immediate bowel protection, broad-spectrum antibiotics, and prompt surgical exploration to reduce the risk of strangulation, peritonitis, and extensive bowel loss.

Intestinal evisceration is associated with substantial morbidity and mortality, reported at approximately 15–20% and 6–8%, respectively [8,9]. The severity of outcomes is strongly influenced by the timing of diagnosis and surgical intervention, as delayed management increases the risk of bowel strangulation, ischemia, and secondary peritonitis. In this context, early multidisciplinary management is essential, including prompt resuscitation, administration of broad-spectrum antibiotics, and timely surgical exploration.

Surgical treatment is dictated by intraoperative bowel viability. When ischemia or necrosis is identified, bowel resection with primary anastomosis or stoma formation is re-

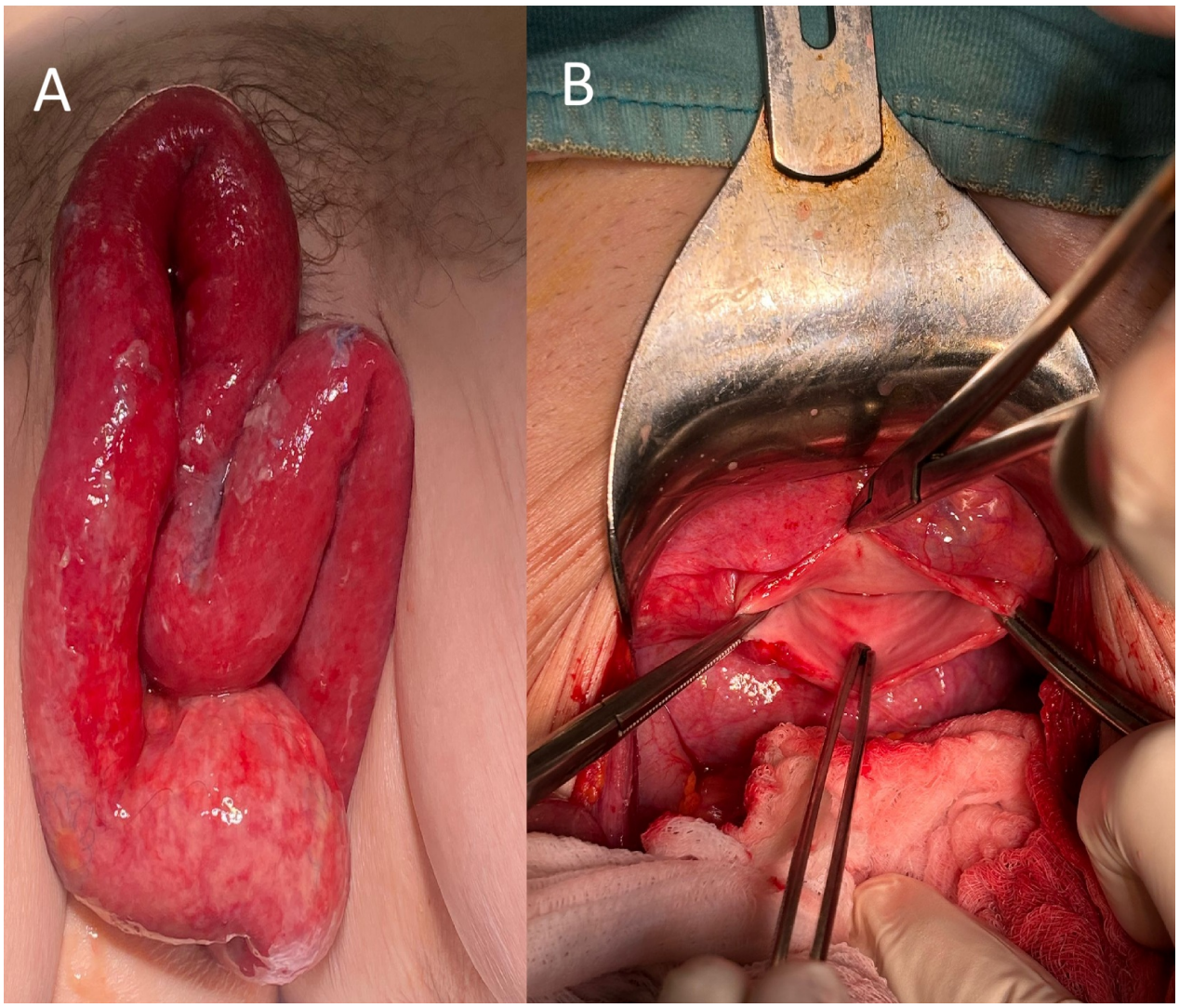

Fig. 2. Clinical and intraoperative findings. (A) Clinical presentation showing transvaginal evisceration of edematous small bowel loops at admission. (B) Intraoperative view demonstrating the vaginal cuff laceration and eviscerated small bowel during surgical exploration.

quired; conversely, in cases with viable bowel, repair of the vaginal defect without intestinal resection may be sufficient. In postmenopausal women, transvaginal intestinal evisceration is most often associated with previous vaginal surgery and pelvic floor disorders, in the setting of multiple synergistic risk factors such as hypoestrogenism, vaginal atrophy, and tissue devascularization. Our case highlights the importance of early recognition and individualized surgical decision-making to minimize the need for bowel resection and reduce postoperative morbidity.

Availability of Data and Materials

The data analyzed are available from the corresponding author upon reasonable request. The data are not publicly available due to information that could compromise the privacy of research participants.

Author Contributions

FC, RB, GS: conceptualization, data curation, formal analysis, investigation, methodology, project administration, software, and writing—original draft. SDM, AnC, AuC, FB: conceptualization, resources, supervision, validation, visualization, and writing—review & editing. All authors have been involved in revising the manuscript critically for important intellectual content. All authors gave final approval of the version to be published. All authors have participated sufficiently in the work to take public responsibility for appropriate portions of the content and agreed to be accountable for all aspects of the work in ensuring that questions related to its accuracy or integrity.

Ethics Approval and Consent to Participate

Ethics committee approval was not required for this single-patient study, as it involved only a retrospective description

of standard clinical care and no experimental intervention. Written informed consent was obtained from the patient for publication of the case details and any accompanying clinical images. The manuscript was prepared in accordance with the principles of the Declaration of Helsinki.

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Conflict of Interest

The authors declare no conflict of interest.

References

[1] Hyernaux M. Traumatic rupture of the vagina; exit of the intestines to the outside; application of large forceps to the upper strait; healing. Bulletin et Mémoires de l'Académie Royale de Médecine de Belgique. 1864; 2: 957. (In French)

[2] McGregor AN. Rupture of the vaginal wall with protrusion of small intestine in a woman 63 years of age; replacement, suture, recovery. BJOG: An International Journal of Obstetrics & Gynaecology. 1907; 11: 252–258.

[3] Arabadzhieva E, Bulanov D, Shavalov Z, Yonkov A, Bonev S. Spontaneous transvaginal intestinal evisceration in case of long-standing uterine prolapse. BMC Surgery. 2022; 22: 157. https://doi.org/10.1186/s12893-022-01615-x

[4] Kowalski LD, Seski JC, Timmins PF, Kanbour AI, Kunschner AJ, Kanbour-Shakir A. Vaginal evisceration: presentation and management in postmenopausal women. Journal of the American College of Surgeons. 1996; 183: 225–229.

[5] Partsinevelos GA, Rodolakis A, Athanasiou S, Antsaklis A. Vaginal evisceration after hysterectomy: a rare condition a gynecologist should be familiar with. Archives of Gynecology and Obstetrics. 2009; 279: 267–270. https://doi.org/10.1007/s00404-008-0820-3

[6] Guttman A, Afilalo M. Vaginal evisceration. The American Journal of Emergency Medicine. 1990; 8: 127–128. https://doi.org/10.1016/0735-6757(90)90199-a

[7] Ribeiro SP, Silva AC, Maciel J, Antunes AS. Spontaneous transvaginal evisceration: a case of recurrence. BMJ Case Reports. 2016; 2016: bcr2015211659. https://doi.org/10.1136/bcr-2015-211659

[8] Wan Hassan WA, Narasimhan V, Arachchi A, Manolitsas T, Teoh W. Small bowel evisceration from vagina. Journal of Surgical Case Reports. 2021; 2021: rjab343. https://doi.org/10.1093/jscr/rjab343

[9] Joy SD, Phelan M, McNeill HW. Postcoital vaginal cuff rupture 10 months after a total vaginal hysterectomy. A case report. The Journal of Reproductive Medicine. 2002; 47: 238–240.

[10] Croak AJ, Gebhart JB, Klingele CJ, Schroeder G, Lee RA, Podratz KC. Characteristics of patients with vaginal rupture and evisceration. Obstetrics and Gynecology. 2004; 103: 572–576. https://doi.org/10.1097/01.AOG.0000115507.26155.45