

Fimbrial Prolapse after Abdominal Hysterectomy: A Case Report

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Abstract

Prolapse of the fallopian tube into the vaginal vault is a rarely reported complication and clinicians can miss the diagnosis when dealing with posthysterectomy vaginal bleeding and discharge. Condition can be confused with vault granulations and serious conditions like recurrent cancer in vaginal vault. We present a case of posthysterectomy fimbrial prolapse in a 40 years old patient as I encountered it for the first time in 20 years of practice. She was referred from different center outside Ranchi to our medical college and hospital in obstetrics and gynecology outpatient department. On naked eye examination, it appeared to be granulation tissue, but when traction test done along with sonography, diagnosis of fimbrial tube prolapse was confirmed and effectively managed.

Key words: Granulation tissue, Hysterectomy, Infection, Vagina vault

INTRODUCTION

Incidence is <1% of all hysterectomies and much lower in better centers. Though it is a benign condition, failure to diagnose it in time and treat appropriately may prove harmful to the patient. Hysterectomy is the most frequently performed surgical procedure.¹ Post hysterectomy prolapse of fimbria is a rare event. Since the first description of this condition by Piozzi in 1902, fewer than reported so far, the majority following vaginal hysterectomy probably due to non-closure of the vault and the pelvic peritoneum.² This condition is omitted from modern textbook of gynecology because of its rarity.³ Fallopian tube prolapsed should be considered in all cases of pelvic or abdominal pain accompanied by vaginal bleeding or discharge after hysterectomy with or without granulation tissue in the vaginal vault. The predisposing factor is the development of abscess at the vaginal apex, which later on leads to prolapse of fimbria through the vault. Total salpingectomy with closure of the vault defect is considered to be the

optimal management because partial salpingectomy can result in recurrence of vaginal discharge and continuing traction on the tubal remnant can lead to persistent pain and dyspareunia.⁴

CASE REPORT

A 40-year-old female came in the outpatient department with a complaint of watery discharge per vaginum, which was excessive in amount. She had to apply sanitary pad. She had three living children, all full term normal deliveries. Her tubectomy was done 10 years back. She underwent abdominal hysterectomy 1 year back in some private hospital at Hazaribagh. Indication of hysterectomy was menorrhagia not responding to medical treatment. Just after the operation she started having vaginal watery discharge. She was in discomfort, so went to her doctor. She took medication for 3 months but no relief. Later on her doctor referred her to our institute in outpatient gynecology department. Details of operation were not available. Her post-operative period was uneventful. There was no history of fever, postcoital bleeding or dyspareunia except for watery discharge per vaginum. General and systemic examination revealed no abnormality. Speculum examination revealed pink fleshy mass near the right angle of the vaginal vault (Figures 1 and 2). This lesion did not bleed on touch during the process of obtaining a pap

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Figure 1: Fallopian tube prolapsed mimicking vaginal vault granulation



Figure 2: Fimbrial prolapse through vault

smear. Bimanual pelvic examination revealed no pelvic mass. Finding was further confirmed by traction test. The prolapsed tissue was held by sponge holder, and traction was given, the patient felt excruciating pain. Her routine investigations were normal. Vault smear was taken, which showed superficial and intermediate squamous cells with few clusters of endocervical cells against the normal background. No evidence of dysplasia seen. Sonography showed well defined soft tissue with a cyst of 3.9 mm × 1.9 mm on the right side of the vault. In view of above finding, she was subjected to laparotomy. The right angle of the vault was carefully dissected, pushing the bladder down, and the vault was opened, fimbria was pulled out, prolapsed part was cut and ligated and tissue sent for histopathological examination (HPE). Pankreatin antibodies can be used to detect fallopian tube epithelium immunohistochemically and this is a valuable approach.⁵ Vault closed with interrupted sutures and abdomen closed in layers. Stitches removed on 8th post-operative day. Perineal swabbing with antiseptic was done and discharged

with proper advice. HPE report showed acute on chronic endosalpingitis.

DISCUSSION

The incidence of fimbrial tube prolapse is 0.5% with a vaginal hysterectomy and 0.06% with abdominal hysterectomy and 0% with laparoscopic hysterectomies.⁶ Risk factors for development of this condition include low socio-economic status, post-operative formation of hematoma and/or infection of the vault and an open vaginal cuff.⁷

The mean time interval between hysterectomy and development of fimbrial prolapse is about 4 months, and the longest interval is 32 years.⁸ Diagnosis is made by traction test. If it is vault granulation or a primary/recurrent cancer, the held portion get detached easily and painlessly. If it is fimbrial tube prolapse then patient experiences pain. However, histopathology leads to definitive treatment. Fimbrial tube prolapse needs to be differentiated from adenocarcinomas, primary and metastatic, endometriosis, cyst of the mesonephric and paramesonephric duct and vaginal adenosis,⁹ however, the appearance is distinct and should not be confused with fimbrial prolapse. Electrocauterizing the prolapsed fimbria thinking it to be granulation tissue may produce catastrophic result as bowel lies in close proximity to the tube.

CONCLUSION

Fixation of accessories onto the pelvic wall and complete peritonisation at the time of hysterectomy are the most important method to prevent fimbrial tube prolapse. Meticulous closure of pelvic peritoneum and vaginal vault separately, achieving haemostasis prior to closure, practice of not fixing the vault to cornual pedicles are the approaches to avoid this complication. Systematic salpingectomies during conservative hysterectomies may be an appropriate approach to prevent fallopian tube prolapse, it would prevent not only fallopian tube prolapse but also tubal and serous ovarian cancer.¹⁰ Most of the cases are misdiagnosed as granulation leading to delayed diagnosis and potentially catastrophic complications i.e., peritonitis. Potential implication of younger age to the occurrence of fallopian tube herniation. Earlier resumption of sexual intercourse before complete healing of vaginal cuff is suggested to be the precipitating event, other predisposing factors are malnutrition, poorly controlled diabetes mellitus, chronic cough and chronic constipation. Post-operative vault infection or haematoma formation, malignancy and tissue radiation are other causes.

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