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PELVIC EVISCERATION – THE PROBLEM OF MODERN SURGERY (METHODS OF PREVENTION AND TREATMENT)

[1]*Ph.D., Associate Professor* ***Strakhovetsky V. S.,***
[2]*Ph.D., associate professor* ***Shchedrov A. O.,***
[1]*Doctor of Medicine, Professor* ***Veligotsky O. M.,***
[3]*doctor of medical sciences, professor* ***Teslenko S. M.,***
[3]*Ph.D., Associate Professor*[3] ***Goncharova N. M.***

Ukraine,
[1] Kharkiv Medical Academy of Postgraduate Education Ministry of Health of Ukraine, Department of Endoscopy and Surgery;
[2] Kharkiv National Medical University Ministry of Health of Ukraine, Department of Obstetrics and Gynecology №1;
[3] Kharkiv National Medical University Ministry of Health of Ukraine, Department of Surgery №2;

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ABSTRACT
The pelvic evisceration is a potentially morbid complication of modern endosurgery. It happens during 6 months after laparoscopical hysterectomy and is a result of postcoital vaginal rupture. The situation needs the urgent operation. In order to prevent this complication it should be prescribed the antibiotics per vagina and what is especially impotent the peritonisation will practically except the chance for a vaginal rapture and a bowel evisceration by vagina. The proposed tactic of patient management after the above-mentioned operations (mandatory peritonitis and local antibiotic therapy) virtually eliminates the gap in the cranny of the forebrain, thereby ignoring the chances of pelvic evisceration.

Introduction. In today's conditions, electrosurgery is gaining in popularity. There are probably no surgeons around the world who would not use modern surgical energies, in general, different types of electrosurgery. Mono-, bipolar current, argon-plasma coagulation, radio-wave coagulation, ultrasound have become widely used in our country. These types of energy are used both in open surgery and in endoscopic methods of treatment.

In modern gynecological surgery, as well as oncogynecology, practically all volumes of interventions are performed by laparoscopic access. Even the most complicated operations, as practice shows, are increasingly becoming the prerogative of laparoscopic surgery. Generally, lymphatic dissociation with laparoscopic access is more effective at times and is associated with a small percentage of complications in the perioperative period, rather than classical lymph node dissociation by the open method.

It should be noted that the most popular laparoscopic operation in gynecology and oncogynecology is panhysterectomy or uterine extirpation. Typically, bipolar and monopole types of coagulation are used for this volume of intervention.

Exactly the extraction of the uterus from the vagina is performed by monopolar current in the cutting mode. Further, after removal of the removed organs from the abdominal cavity through the vagina, it is customary for the sutures to be applied between the anterior and posterior vaginal walls at the level of the cavities or on the upper and lower extremities of the vagina, depending on the extent of the intervention. It is this operation with laparoscopic access that is the reason for the emergence of the pelvic gut entrainment through the arch of the vagina [3, 4].

Also, it should be noted that under the present conditions, during the laparoscopic extirpation of the uterus, there is no stage of peritonitis, which in many other domestic and foreign authors does not make sense, and the leaves of the parietal vein without a surgical eruption regenerate rather quickly.

When reviewing contemporary domestic and foreign literature, we practically could not find enough information on the subject of pelvic evisceration.

It is known that the first case of pelvic evisceration was recorded in 1861 by a German citizen after uterine extirpation when she lifted a bag of coal.

According to some authors, pelvic equation is encountered as a complication of a transmitted laparoscopic pancreatic thrombosis or radical hysterectomy only in 0, 26 % of cases [1, 3, 4].

In our opinion, this information is not entirely valid and its absence in the domestic literature does not imply the absence of the above problem [2].

In this way, we consider it necessary to highlight the experience of the department in the prevention and treatment of this problem.

Purpose: to reduce the frequency of pelvic evisceration after laparoscopic uterine extirpation.

Materials and methods. Annually, at the clinical bases, there are about 700 laparoscopic extirpations of the uterus. A total survey of 2,800 patients operated during the period from 2014 to 2017 in the volume of the laparoscopic extirpation of the uterus. For this period, 55 cases of pelvic evisceration were recorded (2 % of cases). Quite a small percentage, but these patients needed surgical intervention [3].

Results and discussion. A retrospective analysis of all cases of pelvic evisceration was performed. First of all, there was no case within the next 2 months of the postoperative period, which we associate with the absence of sexual intercourse during the specified period (according to our recommendations sexual intercourse is prohibited within 2 months). All cases of pelvic integrative of the small intestine occurred during the next 4 months of the postoperative period. In 100 % cases, pelvic evisceration occurred within 24 hours after sexual intercourse. Only in 2 women pelvic evisceration took place in 1 year and half years, respectively, and was not related to sexual intercourse, but happened within a day after: in the first case - excessive physical activity, in the second - intestinal fastening when straining. Thus, the pelvic evisceration during 6 months of the postoperative period is directly related to the sexual intercourse and is a consequence of the rupture of the arch of the vagina at the site of its stitching.

It should be noted that in all patients with pelvic evisceration, after the vaginal arch was broken, the stage of peritonitis was not performed.

In our opinion peritonitis after laparoscopic extirpation of the uterus or panhysterectomy and especially radical hysterectomy is a necessary stage of the operation. The purpose of this stage is the fencing of the sewn cavity of the vagina from the abdominal cavity, which is personally important for its full healing (mono- and bipolar coagulation in the suture region always leads to healing by the secondary tension, the appointment of antibacterial suppositories transvaginally accelerates the process of forming a full-fledged scar, but the intestinal cornea of the vagina is the lowest part of the abdominal cavity and purely mechanically takes over the load of the higher organs so that the peritonitisation of this area will reduce the load step and the same conditions will be created for proper formation of scar). This technique of patient management virtually ignores the chances of pelvic equation. Full-fledged sexual life is possible in 2 months.

Conclusions. The pelvic evisceration of the small and large intestines due to the rupture of the vaginal arch after previously performed laparoscopic access to uterine extirpation or radical hysterectomy is a dangerous complication requiring immediate surgical intervention. The proposed tactic of patient management after the above-mentioned operations (mandatory peritonitis and local antibiotic therapy) virtually eliminates the gap in the cranny of the forebrain, thereby ignoring the chances of pelvic evisceration.

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