

Prolapse of the Fallopian tube into the vaginal vault

E. Aboud, MRCPI MRCOG

All Saints Hospital, Chatham, Kent - U.K.

Received April 20, 1997; revised manuscript accepted for publication June 10, 1997

Case Report

A 34 year old Para 4+2 underwent a vaginal hysterectomy for heavy and painful periods in August 1994. The operation was straight forward and the vaginal mucosa and peritoneum were closed separately at the vault with 0 Vicryl sutures. Her recovery was uneventful and she was allowed home six days after her hysterectomy.

For the next seven months she complained of severe abdominal pain, vaginal discharge and deep dyspareunia and was treated with numerous courses of antibiotics to no avail. She was referred for a 2nd opinion and was admitted for examination under anaesthesia and laparoscopy. She was found to have a soft red lesion protruding into the vagina at the vault, consistent with a prolapse of the Fallopian tube. Laparoscopy showed the large bowel was adherent to the vaginal vault and omental adhesions covered the tubes and ovaries. A biopsy of the vaginal lesion confirmed the clinical diagnosis. The patient was admitted one month later for bilateral salpingectomy. Both ureters were stented after the induction of the anaesthesia. After the large bowel was mobilised, both Fallopian tubes were removed and the vault was closed with Vicryl sutures. She made an uneventful recovery.

Discussion

Prolapse of the Fallopian tube following vaginal or abdominal hysterectomy is probably much more common than the number of reports in the literature indicate. In the above case the correct diagnosis was not made initially

and the patient was treated with recurrent courses of antibiotics. Once the correct diagnosis was made the Fallopian tubes were removed through an abdominal incision. A biopsy is necessary to differentiate between this condition and the presence of excessive vaginal granulation tissue and to avoid unnecessary cauterisation of a prolapsed Fallopian tube.

Some authors have suggested that it might be simpler to excise the tube through the vagina [1]. In this case, with the amount of adhesions seen at laparoscopy it was felt it would be safer to carry out a laparotomy. Factors which seem to favour tubal prolapse are sepsis, poor haemostasis, combined closure of peritoneum and vagina at hysterectomy and the use of drains [2].

References

- [1] Bilodeau B.: "Intravaginal prolapse of the Fallopian tube following vaginal hysterectomy". *Amer. J. Obstet. Gynec.*, 1982, 143, 970.
- [2] Carmichael D.: "Prolapse of Fallopian tube into the vaginal vault". *Amer. J. Obstet. Gynec.*, 1976, 125, 266.

Address reprint requests to:
Mr. E. ABOUD, MRCPI, MRCOG
Department of Obstetrics and Gynaecology
St. Thomas' Hospital
Lambeth Palace Road,
London SE1 7EH (United Kingdom)