Case Report

Pregnancy with incisional scar evisceration of fallopian tube: A rare case report

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Abstract

Scar herniation of solid abdominal and pelvic organ, other structures, for example, fallopian tube, is extremely rare in the pregnant women. Incisional hernias are not uncommon but obstetric complications during pregnancy due to an incisional hernia are very rare. Here, we report a case of fallopian tube evisceration or incisional hernia through a previous scar. A 26-year-old young female, G2P1L1 at 26 weeks of gestation with a history of previous cesarean section presented to our hospital with complaints of something coming outside of abdomen through the left side of the previous scar on the anterior abdominal wall since 15 days. The patient was examined and investigated and planned for laparotomy. Her preoperative finding was there was herniation or prolapse of fimbrial part of fallopian tube through scar was found. Gravid uterus size was corresponding to 26 weeks of gestation age. Right adnexa and left ovary were normal. Prolapse was reduced manually and abdomen closed back in layers. Her postoperative period was uneventful and discharged with stable maternal and fetal condition. Fallopian tube evisceration is usually prone to misdiagnosis or delayed diagnosis. These cases should be managed by high index of suspicion. These cases are a diagnostic challenge to an obstetrician.

Keywords: Evisceration, fallopian tube, pregnancy

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INTRODUCTION

Fallopian tube evisceration is a type incisional hernia, which is very rare or uncommon in pregnancy. An incisional hernia is due to failure or poor healing of fascial tissues after laparotomy or after any type of abdominal wall incisions, for example, cesarean section. The incidence of hernia in pregnancy after cesarean is 3.1%.[1,2] It is associated with numerous complications, for example, spontaneous rupture, but it is rarely seen. Only a few cases reported till now.[3]

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CASE REPORT

A 26-year-old young female G2P1L1 at 26 weeks of gestation with a history of previous cesarean section presented to our hospital with complaints of abdominal pain and discharge, which was serosanguinous in nature, complaints of something coming outside of lower abdomen through the left side of the previous scar on the anterior abdominal wall since 15 days. According to the patient, there was no history of any trauma, h/o fall, heavy weight lifting, chronic cough, and constipation. The patient had undergone lower

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segment cesarean section 3 years back and was complicated by postoperative wound infection and wound healed by secondary intention. On examination, her general condition was poor, malnourished, *and* hydration was fair. Vitals were stable. Her per abdomen examination findings were a hole of 1.5–1.5 cm with swelling all around with everted skin margin on the left side of the previous scar of lower segment cesarean section on the anterior abdominal wall. There was protrusion of some fimbria like structure with oozing of serosanguinous discharge. Swelling was reducible in nature and tender. Generalized abdominal tenderness was present. Gravid uterus size corresponds to 26 weeks of gestation. On auscultation, fetal heart rate 165 beats/min, unstable lie. Per vaginal examination revealed – internal os closed, cervix uneffaced. Her investigation revealed hemoglobin 10.5 g%, total leukocyte count 12,000/mm^3, and random blood sugar 105 mg%. Transabdominal ultrasound revealed subcutaneous adnexa impaction with the single live intrauterine fetus, gravid uterus size 26 weeks, and rest investigations were within normal limits. The patient was diagnosed as a case of pregnancy with a ruptured incisional hernia, prepared for emergency laparotomy [Figures 1 and 2].

Intraoperative finding:

1. There was herniation or prolapsed fimbrial part of fallopian tube through the scar was found
2. Gravid uterus size was corresponding to 26 weeks of gestation age
3. Right adnexa and left ovary were normal
4. Sheath repaired with prolene number 1 suture and excessive, lax and thickened skin were trimmed.

Prolapse was reduced manually and abdomen closed back in layers with a drain in situ. Her postoperative period was uneventful and discharged with stable maternal and fetal condition.

The patient was undergone regular antenatal care (ANC) visit and delivered by elective cesarean section with the postpartum intrauterine contraceptive device in situ with hernia repair by nylon number 1. Postoperative period was uneventful with healthy mother and baby.

DISCUSSION

Incisional hernia after lower segment cesarean section has been associated with multiple predisposing factors, for example, wound infections, postoperative septicemia and fever, abdominal distension in postoperative period, hypoproteinemia, malnutrition, anemia, obesity, poor surgical technique, midline vertical incision, wound dehiscence, burst abdomen, chronic disease, previous scar healed by secondary intention, and any intraabdominal infection.[1] Maternal complications commonly seen during pregnancy are spontaneous abortion, antepartum (abruptio placenta) hemorrhage, preterm labor, and spontaneous rupture of lower uterine segment in the intrapartum period, and fetal complications are preterm birth and intrauterine fetal death.[4] Spontaneous rupture of an incisional hernia in pregnancy is a very rare entity. Only one case of fallopian tube evisceration with pregnancy is reported till now.[5] Etiopathogenesis of rupture of hernia in pregnancy associated with so many risk factors, one of them is negligence of any long-standing chronic disease that leads to atrophy and avascular necrosis of the overlying skin. Usually, it is associated with a sudden increase in intraabdominal pressure.

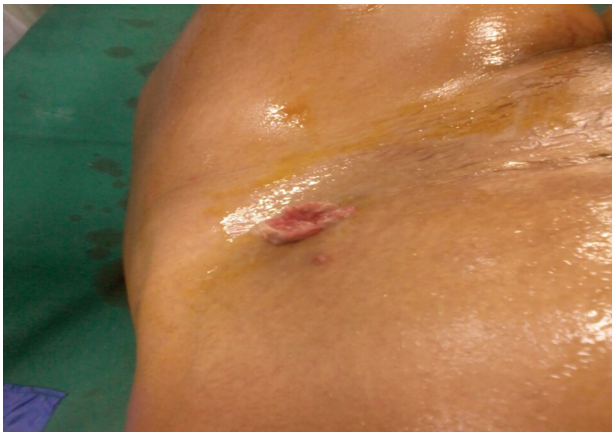

Figure 1: Pregnancy with incisional hernia (lying down position)

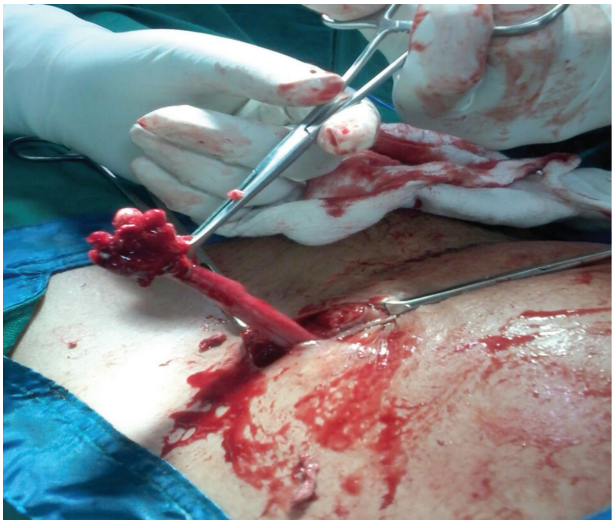

Figure 2: Incisional hernia showing fallopian tube evisceration

There are no evidence-based approach studies been described in literature till now for the management of patients with an incisional hernia in pregnancy, so management of the patient is remain dilemma to obstetrician.

Multidisciplinary team approach is required to manage these patients. Management is individualized and vary according to patient gestational age. Incisional hernias are not an indication of cesarean section. Uncomplicated incisional hernia is usually managed conservatively in the form of manual reduction and abdominal binder till term pregnancy and patient should undergo regular ANC visit.[2,6] Hernia repair should be done in appropriate time, 6–8 weeks after postpartum period. Complicated hernia managed by hernia repair during pregnancy and allowing normal vaginal delivery at term. Uncomplicated unruptured cases should be managed by cesarean herniorrhaphy at 38 weeks of gestation with polypropylene mesh. Recurrence of hernia even after mesh repair is 25%.[2,6]

CONCLUSION

Fallopian tube eviscerations are usually prone to misdiagnosis or delayed diagnosis. Prevention of predisposing factors and good incision with mass closure of rectus sheath by nonabsorbable sutures will decrease the incidence of hernia. These cases should be managed by high index of suspicion. These cases are a diagnostic challenge or dilemma to an obstetrician.

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Conflicts of interest

There are no conflicts of interest.

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