International Urogynecology Journal (2019) 30:1381–1382
https://doi.org/10.1007/s00192-018-3842-9

IMAGES IN UROGYNECOLOGY

Treatment of subacute rectosigmoid obstruction secondary to uterosacral ligament suspension

Rachel High[1] · Jill Danford[1] · Paul Yandell[1]

Received: 31 August 2018 / Accepted: 28 November 2018 / Published online: 5 January 2019

Keywords Uterosacral ligament · Rectal obstruction · Gastrografin enema

A 46-year-old African American woman presented to clinic with abdominal cramping, constipation, and nausea. She was postoperative day (POD) 10 after transvaginal hysterectomy, uterosacral ligament suspension (USLS), anterior and posterior colporrhaphy, and perineorrhaphy for treatment of stage III prolapse (all compartments) and heavy menses. Three sutures were placed bilaterally without difficulty.

She presented to triage with these complaints on POD 9 (Fig. 1) and was given an enema before discharge. On POD 10, she reported emesis. She was afebrile, with a distended, diffusely tender abdomen. Surgical wounds were well healed, and there was no stool in the rectal vault. Imaging confirmed rectosigmoid obstruction (Figs. 2 and 3). Transvaginal release of the left USLS was performed in the operating room (OR). Sutures were in the appropriate location. A large volume of stool was evacuated immediately, and her symptoms rapidly resolved. Six weeks later, her vagina had excellent support and she was having bowel movements daily with milk of magnesia.

Fig. 1 Kidney, ureter, and bladder (KUB) X-ray. Dilated loops of small bowel consistent with ileus; colon full of stool

✉ Rachel High
Rachel.High@bswhealth.org

[1] Division of Female Pelvic Medicine & Reconstructive Surgery, Department of Obstetrics & Gynecology, Baylor Scott & White Health/Texas A&M Health Science Center College of Medicine, 2401 South 31st Street, Temple, TX 76508, USA

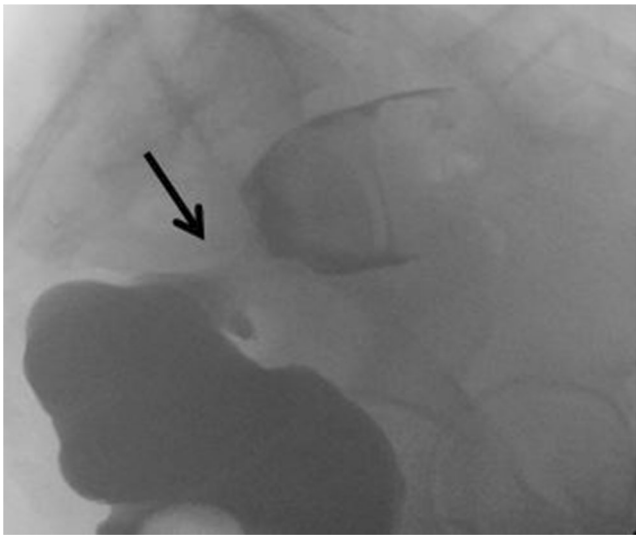

Fig. 2 Single-contrast gastrografin enema. *Arrow*: Focal area of marked narrowing at the rectosigmoid junction with a large amount of formed stool proximal to narrowing

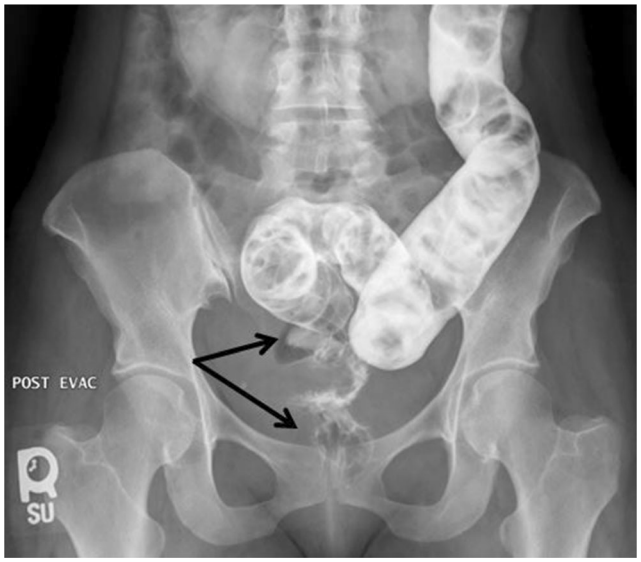

Fig. 3 Single-contrast gastrografin enema (postevacuation). Persistent enteric contrast material to the level of the marked narrowing is noted, with no stool in the rectal vault

This is the first published report of rectosigmoid obstruction after USLS. This is the second known case from a surgeon who has performed >1000 USLS. Both cases involved thin patients, and gastrografin enema aided in diagnosis. We suspect the small pelvis and habitus of this patient led to an overly tight suspension rather than inappropriate suture location.

Transvaginal approach was chosen over laparoscopic due to the precise site of obstruction noted on imaging and exam. Our experience operating on prolapse patients after USLS for other indications is that it is more difficult to access sutures in the laparoscopic compared with the vaginal approach. While constipation is common after surgery, if it does not improve over time on conservative management (stool softeners, laxatives, etc), further evaluation is warranted. With timely diagnosis and removal of the left USLS, morbid sequelae were avoided. To date, there is not evidence to indicate an increased risk of recurrence with unilateral USLS [1].

Compliance with ethical standards

Conflicts of interest None.

Consent Written informed consent was obtained from the patient for publication of this case report and any accompanying images.

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