DOI: 10.34057/PPj.2026.45.01.2025-7-3
Pelviperineology 2026;45(1):44-46

Colossal enterocele repair by modified technique- A case report

Ayesha SHAHID, Nazlı HAMEED, Sheema YOUSAF

Clinic of Urogynecology, Shalamar Hospital, Punjab, Pakistan

Citation: Shahid A, Hameed N, Yousaf S. Colossal enterocele repair by modified technique-a case report. Pelviperineology. 2026;45(1):44-46

ABSTRACT

Enterocele repair is challenging due to different surgical options including opening of peritoneum, removal of hernial sac or plication of uterosacral (USL) ligaments. We present a case report on colossal enterocele repair by a modified technique without opening parietal peritoneum or removing hernial sac. Enterocele was reduced and plication done of rectovaginal fascia with USL ligaments bilaterally.

Keywords: Enterocele; enterocele repair; urogynaecology

INTRODUCTION

Enterocele is a form of pelvic organ prolapse consisting of bowel protruding into the vagina where peritoneum lies directly under vaginal epithelium without any intervening fascia.[1,2] It can be adjuvant with uterovaginal prolapse as presented in our case. Surgical treatment is challenging due to different options including either removal of hernial sac, Moschcowitz or Halban operations or plicating the uterosacral (USL) ligaments like the McCall procedure.[1,2] We are going to report a case of colossal enterocele repair without removing hernial sac or opening the peritoneal cavity. Informed consent was taken from the patient. The aim of the illustration is to provide anatomic insight and surgical steps for a successful repair.

CASE REPORT

A 48-years-age Para 5 previous all normal vaginal deliveries, menopausal for 7 years presented in outpatient department of Urogynaecology, Shalamar Hospital, Lahore. She had bothersome symptoms of something coming out of vagina for the last 12 years with the need of digitation for a year during defecation. Her physical and sexual quality of life has been affected.

On examination, there was Stage IV U-V prolapse and huge enterocele with 3x3 cm decubitus ulcer on posterior wall (Figure 1). Vaginal hysterectomy with enterocele repair was planned. Written informed consent was taken from patient and pre-anaesthesia evaluation done.

Surgical Steps:

Preoperatively bowel preparation was done and antibiotic prophylaxis were administered at induction of anaesthesia. The patient received general anaesthesia and was placed in the lithotomy position.

1. Initially vaginal hysterectomy was performed in a conservative fashion (Figure 2a).

Address for Correspondence: Ayesha Shahid, Clinic of Urogynecology, Shalamar Hospital, Punjab, Pakistan
E-mail: ayeshashahidred@gmail.com **ORCID ID:** orcid.org/0000-0002-7973-0991
Received: 15 July 2025 **Accepted:** 13 April 2026 **Publication Date:** 24 April 2026

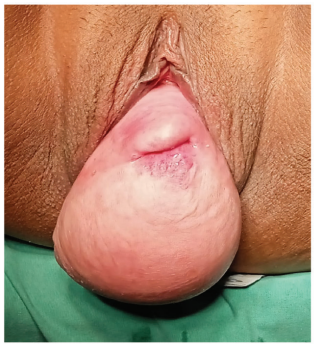

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Figure 1. Stage IV U-V prolapse with huge enterocele

2. Following vaginal hysterectomy, vertical midline incision was given on posterior vaginal to gain access to the rectovaginal space (Figure 2b).

3. Vaginal wall along with rectovaginal fascia dissected in craniocaudal fashion away from underlying enterocele till sac neck was identified. Care was taken to establish a proper plane using metzenbaum scissors as well as blunt dissection using a moist gauze (Figure 2c).

4. The enterocele was isolated without opening parietal peritoneum.

5. Redundant vaginal tissue was trimmed vertically keeping in mind to avoid shortening vaginal length (Figure 2d).

6. Enterocele was reduced and plication done of rectovaginal fascia with USL ligaments identified bilaterally (Figure 2e).

7. Absorbable sutures were tightened to reapproximate apexes of anterior and posterior endopelvic fascia.

8. Vaginal wall closed with absorbable polyglactin vicryl 2/0 (Figure 2f).

RESULTS

The surgery was completed in 100 minutes and blood loss was approximately 200 mL. No surgical complication was detected. Final evaluation exhibited good pelvic support along with well-preserved vaginal length of approximately 8 cm. Patient was discharged and on follow-up of 1 month, she was asymptomatic and no recurrence was observed.

DISCUSSION

Different surgical options are present for enterocele repair through vaginal or abdominal route. They either comprises of using mesh, USL plication, or removing hernial sac. Transvaginal USL ligament suspension along with endopelvic fascia is a well-documented technique as described by Cardozo et al.[1] Our modified technique excludes opening of peritoneal cavity and removing hernial sac to lessen risks of damage to abdominal contents. More enterocele repair cases need to be reported to foster educational material and literature review.

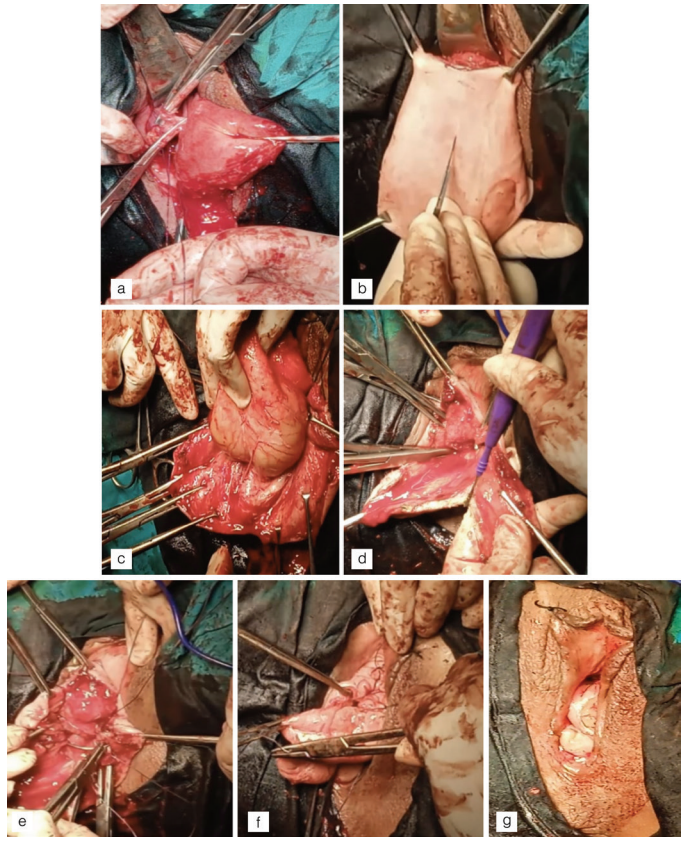

Figure 2. a: Vaginal hysterectomy, b: Vertical midline incision given on posterior vaginal wall, c: Enterocele was cleaved off the rectovaginal fascia, d: Redundant vaginal tissue trimmed, e: USL plication, f: Closure of posterior vaginal wall, g: post-operative picture

USL: Uterosacral

CONCLUSION

This surgical illustration represents a significant tool for learning and important steps for modified procedure for a colossal enterocele repair. Good understanding of anatomy and proper surgical technique is necessary to obtain surgical success with less complications.

ETHICS

Informed Consent: Informed consent was taken from the patient.

FOOTNOTES

Contributions

Surgical and Medical Practices: N.H., Concept: A.S., Design: A.S., Data Collection or Processing: A.S., S.Y., Analysis or Interpretation: A.S., N.H., Literature Search: S.Y., Writing: A.S., N.H.

DISCLOSURES

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study received no financial support.

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