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Case Report

An unexpected bump in the vagina: prolapsed fallopian tube after hysterectomy

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ABSTRACT

Fallopian tube prolapse (FTP) after hysterectomy is an uncommon complication accounting to 0.1% of all hysterectomies without salpingectomy. It may present as vaginal discharge, vaginal bleeding and pain in lower abdomen. It is mostly misdiagnosed as granulation tissue due to its appearance. A 27-years old P3A1L2 woman underwent abdominal hysterectomy 8 months back for heavy menstrual bleeding with chronic cervicitis at a private hospital. Following the surgery, she developed complaint of pain in abdomen and vaginal discharge from last 5 months which was profuse and did not subside despite multiple medications. A per speculum examination revealed a mass like fimbrial end of fallopian tube, which was confirmed on biopsy. She was taken for exploratory laparotomy and on identifying the vault one fallopian tube was seen entrapped within it while the other tube was well visualized entirely. The vaginal vault was opened and prolapsed tube was gently separated from it, and bilateral salpingectomy and vault closure was done. The post-operative period was smooth and finally patient was relieved of her troublesome ailment. Post hysterectomy transient vaginal discharge is a common problem, but it is important to perform the basic examination of the patients to find out the cause. A prolonged duration of vaginal discharge should be dealt with more caution and compassion, especially considering rarest of entities like fallopian tube prolapse.

Keywords: Fallopian tube prolapse, Salphingectomy, Unexpected bump, Hysterectomy, Granulation tissue

INTRODUCTION

Fallopian tube prolapse is a very rare complication after abdominal, vaginal or laparoscopic hysterectomy, with the incidence of about 0.1%. The causes for the same could be due to imperfect peritonization of the vault or inappropriate apposition of the vault, with mobile fallopian tubes.[1] These may occur due to vault hematoma or vault infection, insufficient vaginal preparation prior to surgery, difficult surgery, placement of vaginal drains or packs, tissue fragibility, profuse postoperative vaginal discharge, early resumption of sexual activity after hysterectomy, fever, and with medical conditions like chronic cough, constipation, diabetes and use of steroids. The presentation may be variable like vaginal discharge, vaginal bleeding, post coital vaginal bleeding and pain in lower abdomen. On examination, it mostly appears as granulation tissue, therefore leading to delay in treatment.

CASE REPORT

A 27-years old P3A1L2 with previous vaginal deliveries and abdominal hysterectomy 8 months back presented to us with vaginal discharge from past 5 months which did not subside even after multiple medications which were advised elsewhere. She had undergone abdominal hysterectomy along with unilateral oophorectomy at a private hospital about 8 months back for heavy and prolonged menstrual bleeding and chronic vaginal discharge. Her histopathological reports had features of

chronic cervicitis with squamous metaplasia. When she presented to us, a thorough history was taken regarding indication of hysterectomy and post-operative period, which was uneventful except for few months, when she started developing vaginal discharge. There was no history of post-surgical fever, bleeding PV, early resumption of sexual activity, chronic cough, constipation, diabetes or use of steroids. She was treated with antibiotics elsewhere, but she did not benefit from them. When we examined her, on per speculum examination, non-foul smelling, watery vaginal discharge was present and a red granulation tissue like structure was seen with fimbrial projections at the vault. Rest of the vault was intact on per vaginal examination. Biopsy of this tissue was sent and histopathology confirmed it as fallopian tube with moderate to dense mixed inflammatory cell infiltrates. She was taken for exploratory laparotomy and on identifying the vault one fallopian tube was seen entrapped within it while the other tube was well visualized entirely. The vaginal vault was opened meticulously after dissecting the urinary bladder downwards and prolapsed tube was gently separated from it. Bilateral salpingectomy and vault closure was done. The post-operative period was smooth and finally patient was relieved of her troublesome ailment.



Figure 1: Fallopian tube Prolapse through vault.

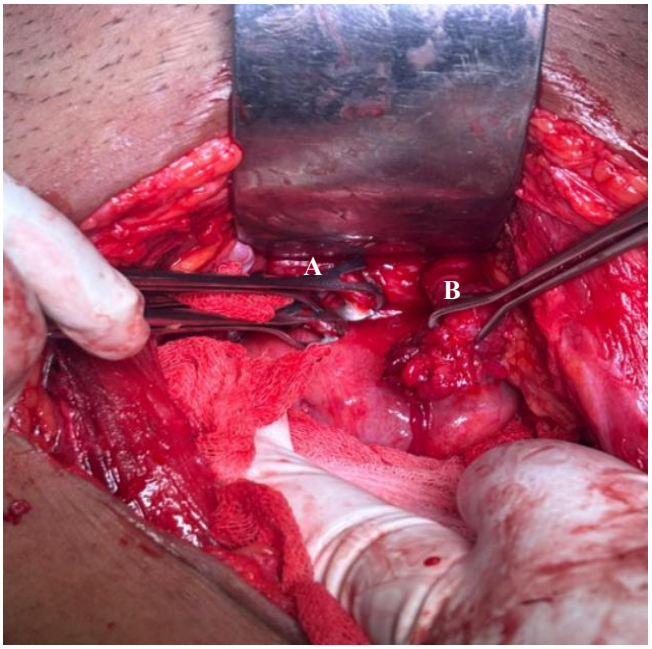


Figure 2: Intra-operative picture, (A) A fallopian tube entrapped in vault, (B) other fallopian tube visualized totally.



Figure 3: Non-visualization of fallopian tube through vault after surgery.

DISCUSSION

Hysterectomy is one of the commonly performed procedure in gynaecological surgeries and every surgery has the chances of post-operative complications. A study done by Fan et al only 0.1 % incidence of FTP after hysterectomy and which further reduced to only 0.06 % of FTP after transabdominal hysterectomy.[1] Occurrence of prolapse after surgery usually varies from as short as 6 months to even reported after 28 years.[2,3] Hysterectomy of pre-menopausal women mostly lead to FTP.

The causes include vault hematoma or vault infection, insufficient vaginal preparation prior to surgery, difficult surgery, placement of vaginal drains or packs, tissue fragibility, profuse postoperative vaginal discharge, early resumption of sexual activity after hysterectomy, fever, and with medical conditions like chronic cough, constipation, diabetes and use of steroids. Therefore, a proper history of the patient is of great importance. The patients with FTP usually present most common with pain abdomen, postcoital bleed, associated with vaginal discharge and dyspareunia. Our case presented with bothersome vaginal discharge, which did not subside despite multiple medications. The diagnosis is difficult as it usually presents as granulation tissue.

A proper per vaginal examination and biopsy of such cases is mandatory. A visual inspection may not always be sufficient as there is other confusing differential diagnosis like granulation tissue, neoplasm of vagina, paravaginal cyst, hematoma, remanent cervical tissue, and bowel prolapsed.[4] The diagnostic modalities include colposcopy, culture of vaginal discharge, colposcopy, biopsy of the prolapsed tissue and vault smear. For definitive diagnosis histopathological examination are required.[5] Other relevant investigations like cystoscopy, ultrasound of vaginal and pelvic organ, abdominal radiograph in upright position, may be needed.[6] When the fallopian tube epithelium is not visualized, it is the immunohistochemistry that helps. IHC for pancreatin is used.

In our case, a visual inspection and biopsy were sufficient for the diagnosis. Management of FTP is mainly surgical. Opportunistic salpingectomy is suggested during hysterectomy to prevent ovarian cancers. The FTP can approach vaginally, laparoscopically or by laparotomy, depending upon individual case, surgeon's experience and choice. Bilateral salpingectomy is the procedure of choice as suggested by most of the case studies following which complete recovery is observed as in our case.[7] Certain difficulties may be encountered during the surgery like dense adhesions, especially adhesion of bladder over the vault and bowel adhesions, but most of the studies did not report any complication during the surgery.

CONCLUSION

Since hysterectomies are rising in number, one must be aware of its complications, especially rare ones, like fallopian tube prolapse. Detailed history taking and visual inspection of vagina and vault along with biopsy are utmost important. Bilateral salpingectomy at the time of hysterectomy provides not only the benefit of prevention of ovarian cancers but also of fallopian tube prolapse and hydrosalpinx in future. Once fallopian tube prolapse is diagnosed, surgical removal is the treatment choice.

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REFERENCES

1. Fan QB, Liu ZF, Lang JH, Sun DW, Leng JH, Zhu L, et al. Fallopian tube prolapse following hysterectomy. Chin Med Sci J. 2006;21(1):20-3.
2. Ang WC, Lenglet Y, Botchorishvili R, Roman H, Canis M, Mage G. Tubal prolapse after total laparoscopic hysterectomy. Gynecol Surg. 2005;2(4):323-7.
3. Varnholt H, Otis CN, Nucci MR, Johari VP. Fallopian tube prolapse mimicking aggressive angiomyxoma. Int J Gynecol Pathol. 2005;24(3):292-4.
4. Silverberg SG, Frable WJ. Prolapse of fallopian tube into vaginal vault after hysterectomy: histopathology, cytopathology, and differential diagnosis. Arch Pathol. 1974;97(2):100-3.
5. Lin YH, Shen HP, Tseng CJ, Wu LY, Hsia LH. Prolapsed fallopian tube to the vagina after hysterectomy a year ago: a case report. Taiwan J Obstet Gynecol. 2025;64(1):155-8.
6. Priya S, Sarojamma C, Sailakshmi MPA. Post hysterectomy fallopian tube prolapse: a rare case. Int J Reprod Contracept Obstet Gynecol. 2019;8(2):769-71.
7. Ouldamer L, Caille A, Body G. Fallopian tube prolapse after hysterectomy: a systematic review. PLoS One. 2013;8(10):e76543.

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