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Research Paper

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KEYWORDS :

Utero-cutaneous fistula – A case report

Dr. N.M.Shah	Additional Professor & HOU, Department of General Surgery, B.J.Medical College & Civil Hospital, Ahmedabad
Dr. Parth R. Dalal	Asst. Prof., Department of General Surgery, B.J.Medical College & Civil Hospital, Ahmedabad.
Dr. Parthraj R. Jadeja	3rd Year resident, Department of General Surgery, B.J.Medical College & Civil Hospital, Ahmedabad.

ABSTRACT

Utero-cutaneous fistula is a rarest of the rare entity for a surgeon or a gynecologist and it requires a great deal of combined efforts by experts of both fields. Here we present a case of a post partum utero cutaneos fistula following a laparotomy for post partum haemorrhage in a 22 year female patient.

Introduction-

Utero-cutaneous fistula is a very rare entity and very few cases are reported till now in literature. Most of the surgeons and gynecologists are familiar with vesicovaginal , ureterovaginal or rectovaginal fistula . Most of these are result of iatrogenic trauma during gynecologic or obstretic procedure[1]. But sometimes it can be due to Crohn's disease , tuberculosis, malignancy or radiation[2]. As far as utero cutaneous fistula is concerned all of them are due to either septic abortion or wound dehiscence of a gynecologic procedure involving uterus. In our case it is due to infection of uterine wall hematoma following uterine suturing in a case of post partum haemorrhage retained placenta.

Case report-

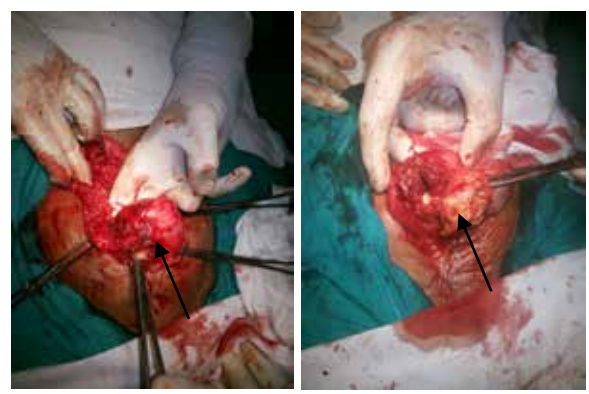
A 22 year gravida 1 para 1 female patient presented at 5 months post partum period with a chronic thick serous discharging sinus with intermittent pus discharge at the lower end of scar of laparotomy done for control of post partum haemorrhage. 5 months ago patient went in to labour pains at full term pregnancy which was complicated by fetal distress and still birth followed by uncontrolled haemorrahge. After failure of non operative methods of PPH control a lower midline laparotomy was done and bilateral uterine artery with bilateral internal iliac artery ligation was done along with B-lynch suturing of uterus. Following this Patient was kept on ventilatory support for 7 days and total 15 blood and 20 component transfusions were done. Patient also developed Disseminated Intravascular coagulation and Acute ranal failure for which hemodialysis was done twice.

After 21st day patient developed abscess at the site of scar which was drained and regular dressing was done. But it was not healing and converted into a thick serous discharging sinus with intermittent pus discharge. Meanwhile patient was still having postpartum amenorrhea.

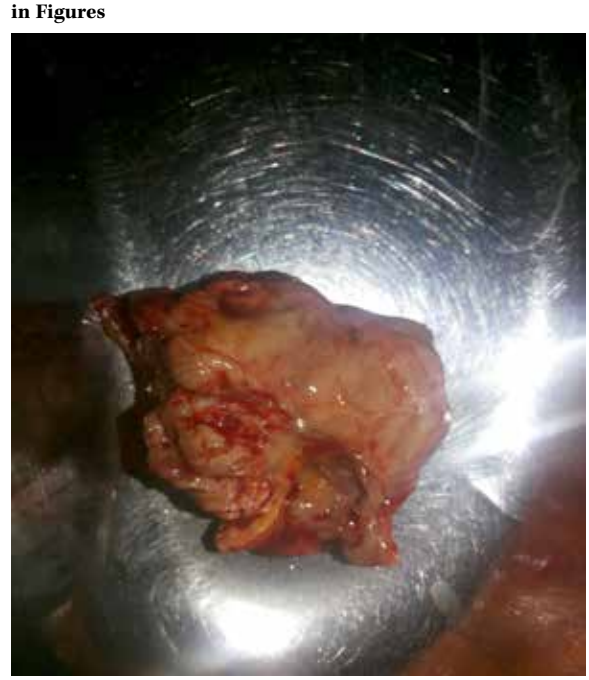
A CT scan was done which was suggestive of intra uterine haematoma with haematoma in relation to the anterior wall of fundus of uterus which was communicating with the anterior abdominal wall via a short fistulous tract passing between two recti abdominis.

After control of infection and correction of anemia surgery was planned. A scar excising incision was kept following probing through the external opening. Tract was dissected off the surrounding adhesions upto uterus. At the uterine end of fistula in the uterine wall a retained part of placenta was found which was adherent to the fundus and posterior wall of uterus and

it was excised . It was of approximately 5*4*3 cm size.



Placenta at the internal end of fistula as shown with arrows in Figures



Excised piece of retained placenta acting as source of infection

Margins of uterus were refreshened and uterus was closed with delayed absorbable sutures polyglactin 2-0. Abdomen was closed with nylon loop no 1 and skin was closed with nylon no

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2-0 by vertical mattress. Post operative period was uneventful. Skin sutures were removed on 11th post operative day.

Discussion-

All fistulas are as a result of local and systemic factors. Presence of foreign body or necrotic tissue (e.g. placenta in this case) at local site acting as a continuous source of infection as well as localized tissue ischemia are important factors for non healing of the wound. Systemic factors like hypoproteinemia, anemia, uremia or generalized infection (e.g TB or HIV) may also hamper local tissue healing[3].

Non healing of superficial wound with persistant discharge from its deeper connection should raise a suspicion of development of fistula and presence of some local factor causing continuous infection.

Most of the cases of genitourinary fistulas are either due to complicated obstetrics or gynecologic procedure. Usually they are the result of breech in the aseptic precautions during these interventions[4].

Number of cases are noted in literature about recto vaginal, vasico vaginal or urethro vaginal fistula. Many of these are associated with accidental injuries during gynecologic procedures like hysterectomies or vault surgeries. Some of the association is also noted with perineal tear either due to obstructed labour or due to episiotomy.

Rarely cases have been reported in the literature about utero cutaneous fistulas. Utero cutaneous fistula is an abnormal communication tract between uterine cavity and skin which is lined by either granulation or fibrous tissue and not by the epithelium.

These patients present either as a chronic, non healing, serous or pus or blood discharging wound. Which can be associated with other symptoms like fever, abdominal pain or leucorrhoea. In present case cause of development of utero cutaneous fistula was retained piece of placenta and B-lynch suturing of uterus as well as ligation of bilateral internal iliac artery leading to localised ischemia. These led to wound dehiscenes and fistula formation.

A retained piece of placenta can lead to other complications like post partum haemorrhage, shock, puerperal sepsis, subinvolution which may require hysterectomy in some cases.

On failure of all the conservative methods of controlling PPH usually only Right internal iliac artery ligation will suffice but if bleeding still continues than Left internal iliac artery may be ligated. Just like in a patient having vaginal vault bleeding after hysterectomy, internal iliac artery ligation is preferred first on the right side and than on the left side after ureteric stent placement.

In this patient B lynch suture was taken to control PPH.

B-Lynch (Brace) Suture

Due to B Lynch suture , there was ischemia in the fundus part anteriorly which ended in to necrosis of the wall of uterus giving rise to adhesion of uterus to the lower end of suture line. Retained placenta and uterine perforation had given rise to uterocutaneous fistula.

Similar such case in the literature are either due to septic abortion[5] or retained tissue during caesarian section[6]. Although surgical excision of the fistulous tract along with removal of the source of infection is the definitive treatment few literatue shows successful medical management by Leuprolide (GnRH agonist). The drug is given for six months. It inhibits menstruation which promotes healing of the fistula in menstruating female.[7][8]

REFERENCE

1. Peri-operative care and complications of gynecologic surgery-Ch 23-286, The Johns Hopkins Manual of Obstetrics and Gynecology 3e. 2. Gynecology and GI Surgeon- Ch 22-401, Shaw's Textbook of operative gynecology 7e. 3. Tissue Renewal and Repair ; Regeneration,Healing and Fibrosis-Ch 3-114. Robbins and Cotran Pathologic Basis Of Disease 7e. 4. Vesico vaginal fistula and urethro vaginal fistula- Ch 39-974, Te Linde's operative gynecology 10e. .5.Utero cutaneous fistula- a case report-post grad med J (1993),69,822,823-S.K.Gupta,V.K.Shukla,D.N.Varma & S.K.Roy 6. J Obstet Gynaecol. 2013 Nov;33(8):906-7.Uterocutaneous fistula following classical caesarean delivery for placenta percreta with intentional retention of the placenta. Athanasias P1, Krishna A, Karoshi M, Moore J, Chandraharan E7. Medical treatment of uterocutaneous fistula with gonadotropin-releasing hormone agonist administration.Seyhan A1, Ata B, Sidal B, Urman B. 8. Int J Gynaecol Obstet. 2014 Mar;124(3):263-4 Successful medical management of uterocutaneous fistula.Yadav P1, Gupta S2, Singh P1, Tripathi S1.