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GASTROCUTANEOUS FISTULA AFTER LAPROSCOPIC CHOLECYSTECTOMY-A CASE REPORT

General Surgery

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KEYWORDS

INTRODUCTION

Gastro cutaneous fistula is an infrequent but serious surgical complication which has received little attention in the recent literature. The current case report is one such example. The fistula, in the current case, occurred at the greater curvature of the stomach and was a result of a previous laparoscopic cholecystectomy done two years before the incidence.

CASE HISTORY

A 45 year old female patient, came to VSGH with chief complains of pus discharge from the epigastric region for the past 6 months.
The patient was operated for laparoscopic cholecystectomy 8 months ago at a private institute.

The patient developed a swelling 6 months ago that gradually increased in size to a size of about 3 cm circumferentially.
The swelling burst and a purulent discharge started coming out of the same.

The discharge ceased for a period of four months and after a brief interval of 10-15 days started again from the same site.

The purulent discharge was not associated with fever, abdominal pain, nausea, vomiting, dyspnoea or any bowel or bladder abnormalities. The patient had no history of tuberculosis.

The patient underwent an abdominal hysterectomy 20 years ago, Is G1P2A0L2, postmenopausal, with no addictions.

OPERATIVE FINDINGS

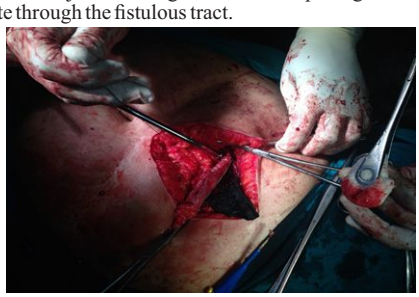
A fistulous tract found to be passing from the skin to the greater curvature of the stomach.

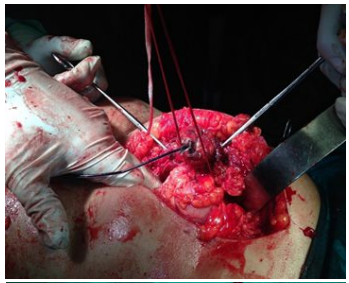
Dense scarring (chronic inflammatory changes) were seen surrounding the fistulous tract.

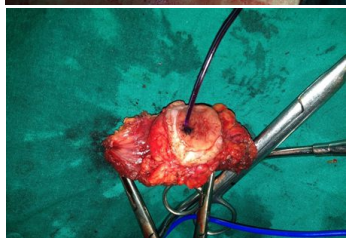
Wall of stomach found to be thickened.

Multiple gall stones identified along the fistulous tract.

Methylene blue injected through the external opening was not found to extravasate through the fistulous tract.







PROCEDURE

In general anaesthesia and supine position, a midline incision kept from the xiphisternum to the umbilicus.

The fistulous tract identified from the external opening to the stomach and subsequently isolated from the surrounding structures.

It was found to contain multiple gallstones along its length with its patency intact up to the stomach.

The tract was excised along with the thickened part of the stomach attached to it.

The stomach was closed in two layers with a delayed absorbable suture material.

A drain was kept in the sub hepatic pouch and the sheath closed subsequently with loop nylon.

CONCLUSION

The possible role of foreign material and inflammation in the formation of gastric fistulas has not been delineated satisfactorily. A relationship between increased incidence of infection in the sub phrenic area and drainage after splenectomy has been documented. Whether gastrocutaneous fistula can be precipitated by inflammatory erosion or sump drain perforation individually remains a moot and perhaps academic point; however, it does occur when both of them are present. The current case delineates an endogenous body (gallstone)

acting as a source of constant irritation and hence inflammation that has caused the development of the tract that has extended to the skin surface. Even though laparoscopic cholecystectomy (LC) has become the customary method for treating gallstones, some incidents and complications appear rather more frequently than with the open technique. Several aspects of these complications and their treatment possibilities are analyzed.

DISCUSSION

Pure gastrocutaneous fistulas are a very rare entity. In large reviews of gastrointestinal tract fistulas, the incidence of isolated gastrocutaneous fistula ranges between 2-20%.[1,2] Indeed many of fistulas are most likely complications of gastrectomy arising from leakage of gastroduodenal or gastrojejunal anastomosis. Ischemic gastric necrosis also has been postulated as etiologically significant in development of gastrocutaneous fistula.

As with other forms of gastrointestinal fistulas, gastrocutaneous fistulas usually arise either from direct or indirect iatrogenic injury to stomach.1 Splenectomy is the operation in which gastrocutaneous fistula results following direct injury to stomach which has been well recognised for many years.[3] Fistulas occurring following laparoscopic surgeries is very rare and usually an iatrogenic cause is suspected. Finally, the possible role of foreign material and inflammation in formation of gastrocutaneous fistulas has not been documented and delineated satisfactorily.

Initial treatment of these fistulas is similar to that for other gastrocutaneous fistulas. Adequate drainage, replacement of required fluid and electrolytes, rational antibiotic therapy and decompression of the GI tract comprise the treatment of choice.[2,4] Intravenous hyperalimentation also aids greatly in nutritional support of these patients.1,5 The eventual outcome for the patient with gastrocutaneous fistula, however, is quite varied and has to be individualized. In the present case, due to apprehension of patient over and above the nature of the fistulous tract, surgical approach was considered.

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