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Case Report Open Access

Case Report of Uterocutaneous Fistula

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Abstract

Uterocutaneous fistula, although not exceptional, is a very rare clinical entity. It occurs most often after uterine or pelvic surgery. We report a case of Uterocutaneous fistula which was formed following lower segment caesarean section. MRI was helpful in the diagnosis and was treated successfully with hysterectomy. This report aims to remind practicing clinicians about this rare complication of caesarean section and discuss our experience with its management.

Keywords: Uterocutaneous fistula; Post caesarean complication; Hysterectomy

Introduction

A fistula is an ab6normal communication between two epithelial surfaces. Fistulas are usually lined by granulation tissue but can get epithelialized. Gynaecologists are familiar with fistulas involving the urinary tract and the genital tract [1]. But uterocutaneous fistula is a rare entity mostly seen after post-partum or postoperative complications [2]. Approximately 120 cases of uterocutaneous fistula have been reported in the world literature in its entirety over the past 200 years [3]. Literature review showed only 25 reported cases in the past 50 years with not more than 3- 4 cases from India. Other causes such as migration of laminaria tent and intrauterine contraceptive devices have also been described [4,5]. There was a decrease of this type of complication corresponding with a decrease in the number of classical caesarean sections performed [6]. Herein we present a case of uterocutaneous fistula developed secondarily to caesarean section treated successfully with surgical management.

Case Report

A 24 year old P2L2 came to casualty with complaints of pain on left lateral edge of pfannensteil scar since 4 days associated with swelling on left lateral edge of pfannensteil scar since 3 days. There is no history of fever or cyclical pain. Her menstrual cycles were 7/30-32 days with moderate flow and were regular since menarche and it was D1 of cycle on admission. She underwent two Lower segment caesarean sections, 2nd caesarean was done 3 years prior to presentation. Patient had similar complaints on right lateral edge of pfannensteil incision 1 year after last caesarean delivery and underwent surgery as said in patient's words for?? Drainage of abscess /??Suture granuloma in an outside hospital for which documented details was not available. Her general physical examination was unremarkable and vitals were stable. On abdominal examination there was a low transverse scar in suprapubic region and non-tender, irreducible swelling of size 4×5 cm on left lateral edge of pfannensteil scar. There was no local rise of temperature and no cough impulse (Figure 1). Patient was not cooperative for speculum examination. On vaginal examination cervix pointing downwards, uterus Anteverted, firm swelling felt in anterior fornix, uterus not felt separately from swelling, non-tender, glove stained with bloody purulent discharge.

USG showed echogenic collection measuring 1.8cm in endometrial cavity leaking through anterior myometrial wall into intramuscular planes from there to subcutaneous planes causing localized collections. (In IM plane measures 5.3×2.2 cm, in SC plane 2.1×0.9cm in left paramedian incisional site) Rt and left ovary – normal (Figure 2). FNAC was done and cytological features were suggestive of scar endometriosis with superadded acute inflammation.

Figure 1: Picture showing swelling on left lateral aspect of scar.

Figure 2: Ultrasound showing communication b/n uterus and subcutaneous planes.

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Patient was started on antibiotics and danazol treatment in view of scar endometriosis and for spontaneous closure of fistulous opening. Patient was readmitted after one month again with increase in size of swelling, increase in pain and history of fever. On examination her vitals were stable, a tender swelling of size 8 x 6 cm seen extending from left lateral edge of pfannenstiel scar present. Local rise of temperature present. Seropurulent discharge present.

Patient was managed with abcess drainage, surgical exploration and subcutaneous tract was excised and started on high dose oral contraceptive pills to suppress menstruation. HPE reported as non-specific inflammation. One of the fragments showed sinus tract lined by non-specific granulation tissue and no endometrial tissue seen in tract. Pt had blood stained discharge from abscess drained site after 1 week for 3 days.

MRI Pelvis was done which showed uteroperitoneal fistula between uterus and intramuscular and subcutaneous planes (Figures 3a and 3b).

Relaparotomy was performed. Intra operatively bladder adhered to previous caesarean scar on uterus, sinus tract extending from previous caesarean scar site to peritoneum, to rectus sheath and to subcutaneous tissue. Tract excised and total abdominal hysterectomy done. (As requested by the couple) (Figures 4a and 4b). Histopathology revealed chronic cervicitis, proliferative endometrium, fistulous tract - chronic nonspecific inflammation foreign body giant cell reaction. Post-operative period was uneventful (Figure 4c).

Uterocutaneous fistula usually results from post-partum or postoperative complications. Most fistulae originate from trauma or some other type of inflammatory processes that disrupt the continuity of tissues involved. The decrease in the incidence of uteroabdominal fistula may reasonably be attributed to marked decrease in the frequency classical caesarean type of operation in modern obstetrics [6,7]. Jain et al. reported uterocutaneous fistula following lower segment caesarean section [8]. Gupta et al. reported uterocutaneous fistula which developed following septic abortion induced by laminaria tent insertion in the cervix [5]. Review of literature also revealed possible etiologies: history of multiple abdominal surgeries, use of drains, incomplete closure of uterine wound following caesarean, intra-abdominal sepsis in previous scar, secondary abdominal pregnancy. In our case the patient had a sinus at the lateral edge of pfannenstiel scar patient might have developed this complication due to post-

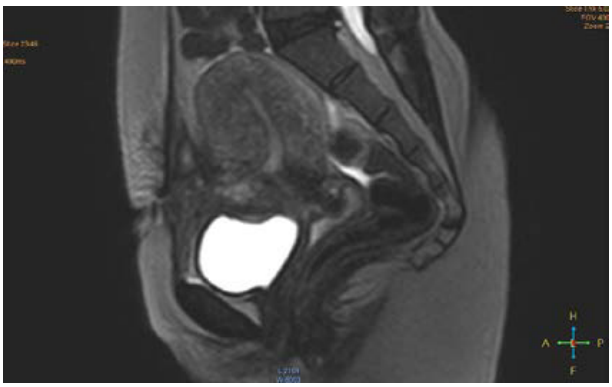

Figure 3a: Saggital view of mri.

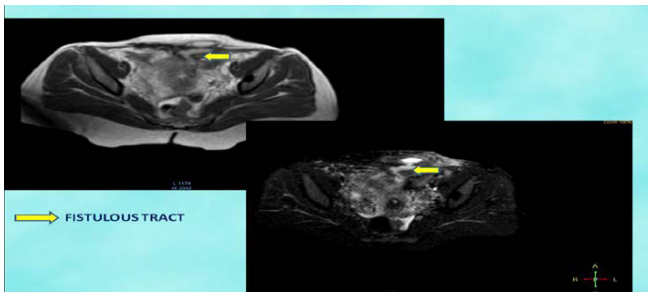

Figure 3b: Axial view of mri.

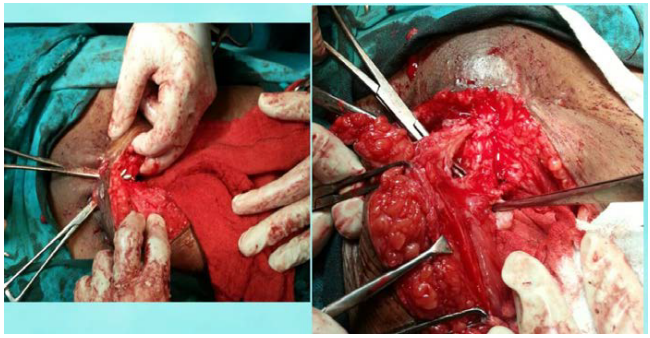

Figure 4a: Fistulous communication.

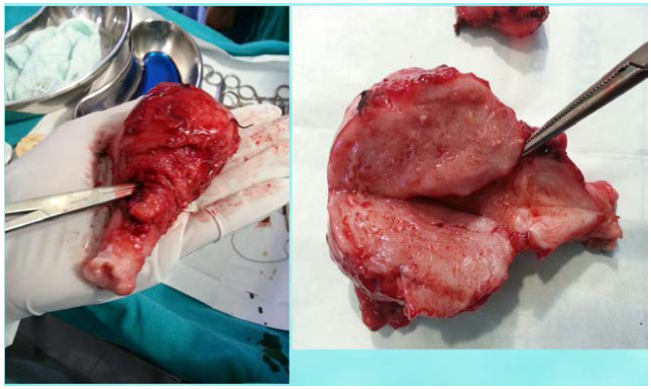

Figure 4b: Fistulous opening.

Figure 4c: Post operative.

operative complication-?? Abscess formation/ suture granuloma. Once a fistula is diagnosed the basic principle in treatment is obliteration of opening of fistulous tract. Utero cutaneous fistulas can be managed medically, but permanent cure remained surgical as evidenced in this case where medical management was failed. MRI has permitted an accurate diagnosis and extirpation of uterus produced a cure. Although medical and surgical treatment is mostly successful, the best treatment of uterocutaneous fistula remains prevention based on better uterine surgery technique, prevention of postoperative infection.

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