Uterocutaneous Fistula Following Cesarean Section, A rare Presentation of Puerperal Sepsis

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ABSTRACT

We present a rare case of uterocutaneous fistula following caesarean section. It is a rare cause of puerperal sepsis. MRI was useful in diagnosis and she was treated with hystrectomy and fistulectomy. This case remainds us to take care of all aseptic precautions during caesarean section.

Keywords: Uterocutaneous fistula, puerperal sepsis, hysterectomy

INTRODUCTION

A fistula by definition is an abnormal communication between two epithelial surfaces. Approximately 120 cases of uterocutaneous fistula have been reported, the world literature over the past 200 years. Literature review showed only 25 reprorted cases over the past 50 years. Only 3-4 cases from india. Previous case reports following caesarean section are associated with red degeneration of intramural fibroid, B-Lynch sutures, insertion of drains, criminal abortion, incomplete closure of uterine wound during caesarean section, inflammatory process related to intrabdominal sepsis and dislocation of intra uterine contraceptive devices [1, 2].

CASE REPORT

A 25 years old Para1 Live1 woman presented to our department with a history of mass and pain at umbilical region since 8 days associated with discharge. She underwent emergency caesarean section 80 days back for fetal distress in outside hospital.

From her record there are no intraoperative complications. she was given 1 unit of PCV transfusion post operatively for haemoglobin being 8 grams. On her 5th POD she developed fever and she was given parentaral broad spectram antibiotics for 14 days. Suture removal was done on 8th past operative day and wound was healthy.

On general examination she was afebrile, no pallor with stable vitals.

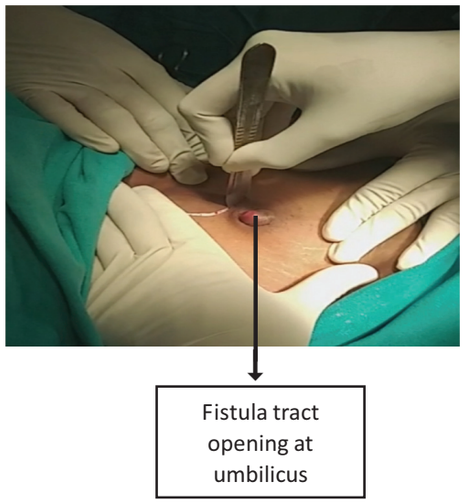

Image 1:Pre operative picture showing mass with fistulous tract opening at the umbilicus.

Abdominal examination revealed healthy pfannenstiel scar, there is a 4×3 cms soft tender, irreducible mass present at umbilicus with a local rise of temperature associated with purulent discharge.(image 1)

Perspeculum Examination: Cervix was drawn up, no abnormal vaginal discharge.

On bimanual Examination: Uterus was drawn up, 8 weeks of size adherent to anterior abdominal wall.

Her complete blood picture , urine analysis, renal, liver functions were normal. Blood culture, high vaginal swab culture showed no bacterial growth. USG abdomen and pelvis reveals uterus 9×5×4.5 cm with 3 mm endometrial thickness with evidence of 6×4 cm. illdefined hypoechoic lesion noted at fundus and body of uterus with loss of endometrium possibility of chronic retained products of conception/organized hematoma.

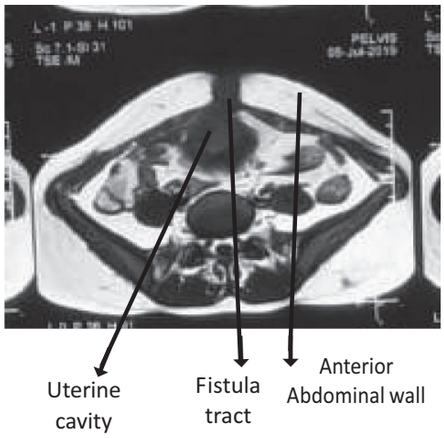

Image 2:Transverse section of MRI abdomen and pelvis showing fistula tract between uterus and skin.

Ultrasound guided FNAC suggested suppurative leasion. MRI abdomen and pelvis reveals placenta increta with areas of placental blood products and focal areas of anterosuperior myometrial dehiscence causing infroumbilical herniation. Serum B-HCG was normal.

She was started on I.V antibiotics posted for laparotomy. Intra operatively dense adhesions present between uterus and anterior abdominal wall. Bowel and omentum adherent to posterior uterine wall. Adhesiolysis done. Tract connecting the fundus and umbilicus loaded with pus present. Hysterectomy was done as entire uterine wall was necrotic. Complete fistula tract exicision was done.

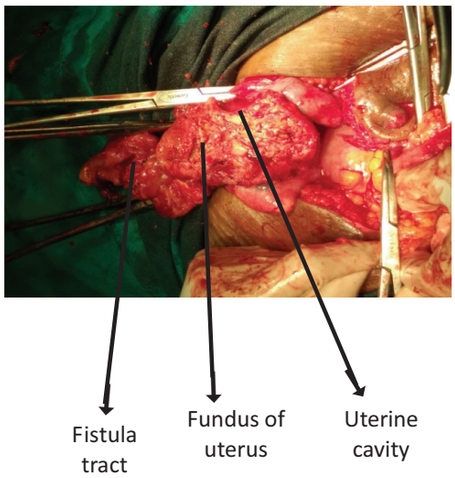

Image 3:Intraoperative picture showing uterine cavity filled with pus and fistula tract connecting to fundus of the uterus.

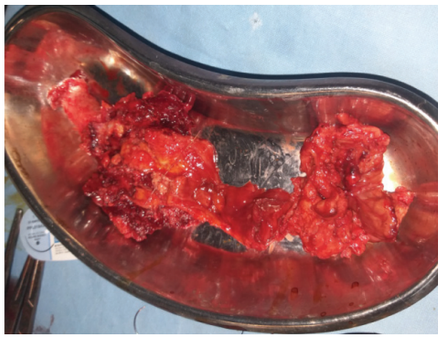

Image 4:Post operative specimen showing necrotic anterior wall of uterus and fistula tract.

Post operative period was uneventful.

Pus and uterine tissue sent for culture and sensitivity showed no bacterial growth.

On Histopathological Examination it was noted to have Myometrial dehiscence with organized hematoma and intermittent areas of fibrosis and calcification and pseudotract.

Uterocuteneous fistula usually results from post operative complication of caesarean section and other pelvic operations[3].

Sheyan et al has previously described a non surgical method involving the use of gonadotropin releasing hormone agonist (GnRHa)[4]. GnRHa works by suppressing menustraction and causes atropy of endometrial like lining of fistulous tract resulting spontenous closure of fistula.

In two case reports one by Shukla et al[5] and another by George Uchenna[6] et al describe conservative surgical approach with excision of fistulas tract and repair of the fistulous uterus.

However in another prior case report of uterocuteneous fistula following term abdominal pregnancy subtotal hysterectomy was performed by Promsonthi and Herabutya et al[7].

Similar to Mounika Thakur et al[8] who performed total abdominal hysterectomy for uterocutaneous fistula following B-Lynch suture. We performed total abdominal hysterectomy with fistulectomy.

CONCLUSION:

This case report highlights rare complication of caesarean section. Appropriate surgical skills following aseptic precautions and good post operative care are necessary to prevent an outcome that may be agonising for the patient. There is no evidence based treatment modality currently available for uterocutaneous fistula. Surgery remains the treatment of choice.

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