UTERO-PARIETAL FISTULA

BY

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A very rare type of genital fistula is the utero-parietal fistula. Such a fistula affords an abnormal communication of the uterine cavity with the anterior abdominal wall through which menstruation occurs.

On reviewing the literature, I could find the report of only 36 cases of these fistulae.

Details of the cases in the literature are given in chronological order in Table I.

TABLE I

Total Cases in the Literature.

Author	Year	Place	Number of cases	Preceeding operation	Post-operative infection
Bircher	1910	Germany	1	Ventrofixation	yes
Loicq	1922	Paris	27	Classical caesarean section	yes
Puccioni	1924	Italy	2	- do -	yes
Price	1928	Kentucky	1	- do -	not mentioned
Devraigne et al	1928	Paris	1	- do -	yes
Ballin	1928	..	1	Myomectomy	yes
Brayne	1930	Malaya	1	Classical ceasarean section	yes
Larini	1932	Italy	2	- do -	nil
Our case	1944	Calcutta (India)	1	- do -	yes
		Total	37		

The first case was reported by Bircher from Germany in 1910 where the fistula developed after a ventrofixation operation. In 1928, Ballin reported a fistula after myomectomy. The remaining 34 cases have all followed caesarean section of the classical type. Loicq (1922) collected 27 cases, Puccioni (1924) reported 2 cases, Price (1928) 1 case, Devraigne et al (1928) 1 case, Brayne (1930) 1 case and Larini (1932) 2 cases. I do not find the report of any case after 1932.

All the fistulae have developed after some operation and the commonest operation producing this complication has been classical caesarean section (94.6%).

Classical caesarean section is an operation which is very commonly done and occurrence of such an inte-

resting complication after caesarean section is worth recording. The following are the details of a case of utero-parietal fistula we came across in the Eden Hospital.

Case Report.

Mrs. A. B., Hindu, aged 25, para 4 was admitted on 15-11-44 in the Eden Hospital, Calcutta, with the complaint of periodic discharge of blood through an abdominal scar for the last 5 months. This discharge was synchronous with menstruation. The menstrual periods were lately profuse and painful.

Patient had four pregnancies previously. First pregnancy in 1936 ended in a premature baby delivered vaginally. In the second pregnancy (1938) the presentation was shoulder and a caesarean section was done to deliver a baby of 7 lbs. weight. This was done elsewhere and details are not available. But the post-operative period was said to be afebrile. The third pregnancy occurred 3 years after the second (1941) and again a classical caesarean section was done for disproportion to deliver a 7 lb. female baby. There was no trouble in the post-operative period. Last pregnancy occurred in 1943 when she attended the Eden Hospital for the first time and a classical caesarean section for disproportion and ligation of tubes was done. The baby was 6 lb. 8 oz. in weight.

After the last caesarean section patient ran a temperature of 102° to 101°. Sulphonamides were given. Several stitch abscesses were formed in the abdominal wall which healed by secondary intention after 3 weeks. The involution of the uterus was delayed and the patient was discharged about 50 days after the operation.

During this caesarean section, silk worm gut and catgut were used for suturing the uterus.

When the patient left hospital there was no sign of any fistula. The abdominal scar was apparently intact and dry. Her menstruation recommenced soon after the operation and she noticed that it was more painful and prolonged than was usual with her before the operation.

In August, 1943, (i.e. 5 months after operation) she noticed discharge of blood through a point in the abdominal scar of the last operation. The discharge appeared only during the menstrual period and in between menstruation the scar was quite dry. No pain or discomfort was complained of.

On examination she was found to be a short woman about 5 ft. in height. A previous skiagram had shown the pelvis to be of the generally contracted type.

Abdominal examination revealed two longitudinal paramedian scars. The scar on the left side which was due to the second caesarean section was found intact. The scar of the first operation had been excised previously. About the middle of the right scar a small opening with a diameter of about ¼" was found with edges inverted. The rest of the scar was healthy. The abdominal muscles were strong and no scar harnia was evident.

A probe was passed through the opening in the scar and it was found to pass almost horizontally back-

wards for a distance of 2 inches. There was no discharge at the time of examination.

The blood for Wasserman Reaction was negative and blood count was normal.

About 20 c.c. of methylene blue were slowly injected into the external opening of the fistula and the dye was seen to flow out of the external cervical os through the speculum placed in the vagina. This confirmed that the fistula had communication with the uterine cavity.

The diagnosis of a post-operative utero-parietal fistula was made and surgical repair was undertaken.

While opening the peritoneal cavity the uterus was found to be adherent to the parietal peritoneum and the proximal end of the fistula was found to have extended to the anterior wall of the uterus near about the fundus.

There was no hernia, neither any part of the gut was adherent to the fistula. The uterus was slightly enlarged but it was otherwise healthy. Considering the young age of the patient it was decided that attempt should be made to conserve the uterus. A wedge-shaped area of the anterior uterine wall encircling the fistula was excised. The endometrium of the cavity of the uterus was found to be healthy. The uterus was then repaired by means of two layers of interrupted chromicised catgut sutures and a third layer of Lembert stitches. The whole tract of the fistula was thus excised and the uterus was found to be anteverted and mobile. Abdominal wall was sutured in layers.

Abdominal wound healed by first intention and convalescence was uneventful. The menstruation which occurred 15 days after the operation was less painful and the blood loss was also moderate in amount.

The patient was examined at regular intervals after the operation. There was no sign of recurrence of the fistula. The uterus was normal in size, mobile and anteverted and the periods were normal and painless.

Discussion.

Utero-parietal fistula is likely to develop after classical caesarean section when there has been frank sepsis present and the post-operative period has been febrile. Using unabsorbable sutures like silk worm gut or silk for suturing the uterus increases the chance of fistula formation. Unabsorbable sutures like silkworm gut or silk should not be used in presence of sepsis.

The diagnosis of utero-parietal fistula is not difficult when the history of a classical caesarean section is borne in mind. The characteristic symptom is discharge of menstrual blood through the abdominal wall. A similar picture of blood discharge may be due to scar-endometrioma, tubo-parietal fistula or granulation tissue. But the diagnosis of utero-parietal fistula is confirmed easily by exploring the tract with a probe or injecting methylene blue (1%) into the tract. If desired a skiagram taken after injecting a radio-opaque dye will show the fistulous tract.

In young patients, the ideal treatment is fistulectomy and repair of the uterus after wedge resection of the affected area. This may not be prac-

ticable in all cases and mostly a hysterectomy is required.

Summary and Conclusion.

A case of utero-parietal fistula after classical caesarean section is reported. The menstrual fistula had developed five months after a classical caesarean section was done for the third time for disproportion. The post-operative period was febrile. Fistulectomy and conservation of the uterus cured the condition successfully and no sign of recurrence has been found.

In the literature of the total 36 cases, 34 cases had followed classical caesarean section. Utero-parietal fistula thus proves to be a rare but important complication of classical caesarean section.

To prevent this complication, classical section should be abandoned in preference to a lower segment operation whenever sepsis is present. It, is safer to use absorbable suture material like catgut for suturing uterus in classical section.

The present antibiotics and increasing preference for a lower segment operation would certainly lower the incidence of utero-parietal fistula. Still whenever a classical caesarean section is done, the risk of this complication should always be borne in mind.

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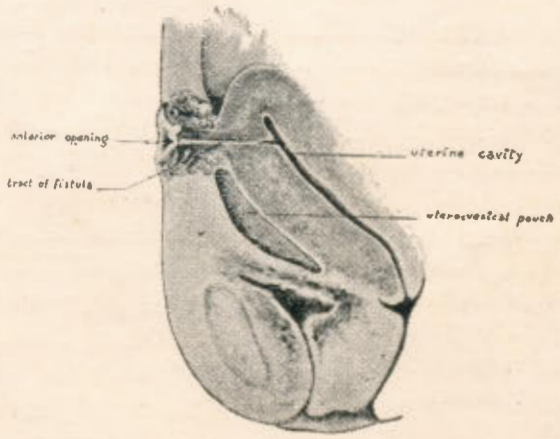

Diagramatic Section of Utero-parietal Fistula.