UTERO-CUTANEOUS FISTULA

(Following Classical Caesarean Section)

by

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Cutaneous fistulae, involving bladder, ureter or bowel following complicated gynaecological surgery, and menstrual fistulae following caesarean section, have been reported in literature — (Laffront A. and Ezes 1947, Case 1955, Falk 1956, Youssef 1957, Kirkland 1959, Moir 1961, and Bhaskar Rao 1961). However, uteroparietal or cutaneous fistula as a sequla of silent rupture of the classical scar is very rare.

Case Report

Mrs. P. I. P. No. 5592, aged twenty years, was admitted into Government Erskine Hospital, Madurai, on 23-5-65 for further treatment after an abnormal delivery. She was married three years ago and had no antenatal care whatsoever for her first pregnancy. At term, membranes ruptured prematurely and she had a prolonged and desultory labour. She was taken to a Government Taluk Hospital five miles from her village. There she was delivered by a classical caesarean section. The baby was still-born. The puerperium was complicated by fever and wound infection and she was discharged from the hospital a month later. It took nearly three months for her to recover fully. Menstruation started four months after the operative delivery and was normal.

She conceived again after another four months. Except for mild morning sickness, this second pregnancy continued uneventful. She was seen in the neighbouring Government Hospital for a check up at the fifth month and was told to report at the ninth month for admission. The patient did not experience any particular discomfort till the thirty-sixth week of pregnancy. She noticed a small bulge in the middle of the abdominal scar just ten days prior to her delivery. Labour pains commenced on 22nd May 1965 and this was soon followed by discharge of blood and blood-stained fluid through the abdominal swelling and vagina. With the pains getting stronger she found to her great dismay the baby's head appearing through the abdominal wound. With a binder around her abdomen she was immediately transported to the Government Hospital, where the doctor found a dead baby half delivered through the abdominal scar of the previous caesarean section. He completed the delivery and removed the placenta also through the same route. He observed that the uterus was completely adherent to the anterior abdominal wall. The uterus was packed with gauze and she was sent to Erskine Hospital, Madurai, on the 23rd May 1965.

On admission her general condition was good. Local examination revealed a right lower paramedian scar. An irregular circular opening was present an inch below the umbilicus and this opening could admit a fist easily. The uterine fundus was two inches above the umbilicus. There was no abdominal distension and there was no bleeding from the wound. Induration and tenderness were present over the scar. She was given antibiotics on admission. The local infection cleared and the uterus involuted normally, and the opening in the abdominal scar gradually shrunk until it

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could admit only a probe. An incisional hernia was also present. A sinogram was done to demonstrate the uterocutaneous fistulous tract. A fine catheter was passed through the abdominal opening into the uterus and lipiodal was injected through it. The fistulous tract, uterus and upper vagina could be visualised (Figures 1 and 2).

It was decided to excise the fistulous tract. A month after her admission she was operated. An elliptical incision enclosing the previous scar and fistula was made. The fistula from the skin was traced down to the anterior wall of the uterus. The bladder was pulled up and was adherent to the lower uterine segment. No unabsorbable suture material was found. The entire sinus tract along with the unhealthy edge of the classical caesarean scar was excised. A two layer repair of the uterine wall was done. Since the risk of scar rupture in a subsequent pregnancy was high in this patient tubal sterilisation was also done. The abdominal wall was then repaired carefully.

A portion of the sinus tract near the anterior parietal peritoneum was sent for microscopic examination. The histopathological report showed evidence of scar endometriosis — G 179/65 — Fibromuscular tissue, infiltrated by dense sheets of inflammatory cells and endometrial glands with evidence of hyperplasia.

She reported for a follow-up on 13th December 1965. The abdominal scar was good. By then she had had three normal menstrual cycles, the flow being moderate lasting for three to four days and painless. Her last period was on 3rd December 1965. Pelvic examination revealed nothing abnormal.

Discussion

Obstetric complications after caesarean section, especially the classical type, are well known. This type of abnormal delivery through the abdominal scar is extremely rare.

It is likely that due to the wound infection following the classical caesarean section, the uterus around the site of the classical scar had got adherent to the anterior abdominal wall. There was clinical evidence of incisional hernia also. The patient was feeling the foetal movements till she got into labour. The uterine contractions during labour must have given rise to rupture of the classical scar and pushed the baby into the incisional hernial sac and finally through the thinned out abdominal scar. Only part of the baby was spontaneously born this way and the rest was helped out by the doctor in the neighbouring hospital. The delay in the delivery accounts for the foetal death. He had also noted that the uterus was adherent to the margins of the opening in the abdominal wall. Clinically, there was no history suggestive of scar endometriosis as the perietal peritoneum close to the uterine attachment only showed endometrium histologically. This may be due to its extension from the opened endometrial cavity.

Summary

An unusual case of utero-cutaneous fistula following classical caesarean section, with the birth of the baby through the abdominal scar in a subsequent pregnancy is reported. Simple excision of the fistula and repair of the uterine wall were carried out.

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