AN UNUSUAL CASE OF URINARY INCONTINENCE DUE TO CONGENITAL URETERO-CERVICAL FISTULA

by

SUBHADRA UPADHYAY,* M.S., M.R.C.O.G.

A very interesting case of urinary incontinence from childhood in an unmarried woman is being presented here because of the great difficulty in its diagnosis and management.

Case Report

Kumari M. K.. aged 22 years was admitted on 27-10-72 complaining of incontinence of urine from childhood.

Menstrual History

She had her menarche at 14 years of age. Her cycles were regular, 2-3-/30 days with moderate flow and mild abdominal discomfort.

Past History: Nothing significant.

On examination

An average built woman with a congenital haemangioma on the left side of face. Her general condition was satisfactory, pulse rate 72/minute, B.P. 120/70 mm of Hg., no lymphadenopathy. Cardiovascular and respiratory systems were normal. Abdominal examination revealed no abnormality.

Pelvic Examination

The external genitalia were normal. No fistula could be located or felt. Uterus, cervix and adnexae felt normal.

Investigations

Haemoglobin was 10.4 gms%, Total R.B.C. was 3.2 mill./cmm. Bleeding time 95 seconds. Clotting time 3 minutes 60 seconds, Total leucocytes 9200/cmm, Differential leucocytes-poly 68%, lympho 20%, eosino 10%, mono 2%.

Department of Obstetric & Gynaecology, P. W. Medical College and Hospital, Patna.

Received for publication on 2-1-73.

Urine:—nil abnormal. Culture, sterile.

Intravenous pyelography: Normally functioning kidneys. No accessary ureter was visualised.

Cystoscopy

Two ureteric openings were seen. Left opening looked inflamed. Bladder mucosa was normal.

Hysterosalpingogram: Normal uterine cavity with tubes showing spill on both sides.

Examination under Anaesthesia

(1) 3 swab test: There was no evidence of any fistula.

(2) Indigo-carmine dye test: On i.v. injection of Indigo carmine no dye was seen coming out through the cervix in the beginning but the cervical mucosa got stained after a few minutes. On dilatation of the cervix the dye was seen coming out intermittently through the cervical canal.

Diagnosis

A probable diagnosis of ectopic ureter communicating with the uterine cavity was made.

Treatment

After the usual preparation for an abdominal operation laparotomy was performed on 7-12-72. On the right side a single ureter communicating with the bladder was seen. On the left side two ureters were seen coming separately. On dissection at the lower end it was seen that one ureter was communicating with the bladder while the other was opening into the antero-lateral wall of the cervix just below the internal os. This ectopic ureter was cut close to the cervix, the distal end was ligated and the proximal end was transplanted into the bladder.

A Foley's catheter was left in situ for 8 days. The patient made a speedy recovery and remained continent thereafter Cystoscopy with indigo carmine i.v. injection showed that the ureter which was transplanted into the bladder was functioning satisfactorily.

Discussion

Congenital uretero-uterine fistula with accessary ureter is an uncommon entity. It causes incontinence of urine which is frequently mistaken for childhood enuresis. The amount of urine escaping is small with an otherwise normal micturition. Intravenous pyelography often fails to reveal the accessary ureter as the part of the kidney served often has a poor function. Hence the diagnosis of such cases is extremely difficult. The case under review had exactly the same difficulty in diagnosis. I.V.P. did not reveal the presence of accessary ureter. It was the indigo carmine dye test which was suggestive of an accessary ureter communicating with the uterine cavity. The dye was not seen coming out through the cervical canal at first, but the cervical mucosa was found to be stained a little later which prompted us to dilate the cervical canal. On dilatation of the cervical canal the dye was seen coming out through the os intermittently. Laparotomy confirmed the diagnosis. The usual treatment recommended in text books for such cases is excision of the ureter along with the excision of that portion of kidney which it serves. In this case since the ureteric efflux was very good though not frequent, it was decided to transplant the ureter into the bladder. The patient made an uneventful recovery. Post-operative cytoscopic examination with 0.4% of Indigo carmine excretion test has proved this management to be rewarding.

Acknowledgement

My thanks to Prof. S. N. Upadhyay, M.D., F.I.C.S., F.A.C.S., F.A.M.S., F.R.C.O.G. for allowing me to manage this case and for permission to publish it.

INSTRUCTIONS TO CONTRIBUTORS

The Journal of Obstetric and Gynaecology of India, which appears bi-monthly, publishes original articles and case reports. Papers submitted for publication should be addressed to the Editor, Journal of Obstetrics and Gynaecology of India, Purandare Griha, 31 C Dr. N. A. Purandare Marg, Bombay 7 WB. Papers are accepted on the understanding that they have not been and will not be published in whole or in part in any other journal and are subject to editorial revision.

MANUSCRIPTS should be **double-spaced typing,** two copies, one **Original and one carbon,** on one side on quarto or foolscap sheets with a margin of not less than two inches. They should bear the full name, qualifications, designation and address of the author. Abbreviations should be avoided as far as possible. Any alteration in the names of authors, their degrees, designations will not be considered once the text has been printed.

Tables:—Tables should be numbered in Roman numerals (Table I, Table II, etc.) and set out on sheets separate from the text with indications, as to where the author desires them to be placed.

Illustrations:—Illustrations too should be kept separate from the text and numbered in Arabic numerals (Fig. 1, Fig. 2 etc.) with indications as to where the author desires them to be placed. The illustrations should be accompanied by relative legends. Nothing should be written or typed on the back of the illustration. Photographs and micro-photographs should be printed on glossy paper. If sent by post, they should not be folded and should be adequately protected. **All illustrations will be printed separately on Indian Art paper.** The Journal will bear cost of preparing blocks for two illustrations (black and white) per article, but the cost of art paper used for printing all illustrations will have to be borne by the contributor.

References:—References should be placed at the end of the article and should conform to the style of the Quarterly Cumulative Index Medicus. Authors quoted should be arranged in alphabetical order of the author's surname, followed by initial, names of Journal, volume number underlined, first page of the article and year, thus "Mitra, Subodh: J. Obst. and Gynec. India, 4: 15, 1963". Citations from the text should be by the author's surname followed by initials, title of the book, edition, place and year of publication, name of publisher and page number, thus: Masani, K. M.: Textbook of Gynaecology ed. 3, Bombay 1960, Popular Book Depot, p. 223. Before sending the paper the authors are requested to correct the typing errors. All the authors mentioned in the text must be given in the list of references at the end of the paper.

Copyright:—Papers which have been published become the property of the Journal and should not be published without the permission of the Editor.

Reprints:—Ten reprints, printed on one side of the paper, will be supplied free of cost to the contributors. A copy of the issue in which the article appears will be sent to any contributor who is not a subscriber. Additional reprints can be purchased by arrangement with the printers if application is made to the Editor at the time of sending the article.

All communications regarding subscription to the Journal, advertisement, reprints, etc., may be addressed to the Secretary, Journal of Obstetrics and Gynaecology of India, Purandare Griha, 31C Dr. N. A. Purandare Marg, Bombay-7.