# ENDOMETRIAL CARCINOMA PRESENTING AS UTERO-TRANSVERSECOLIC FISTULA

## (A Case Report)

by

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Utero-transversecolic fistula formation by direct spread of endometrial carcinoma is a very rare presentation. We could not get even a single reference in the literature. Here we present an interesting case of endometrial carcinoma which manifested as utero-transversecolic fistula.

### CASE NOTES

A forty-five year old multipara was admitted in U.I.S.E. Maternity Hospital on January 1, 1974 with complaints of faecal discharge per Vaginam, bleeding per Vaginam off and on, weakness for one year and pain in lower abdomen for three months. One year back dilatation and curettage of the uterus was done in some hospital and the patient was advised hysterectomy but she refused it. She did not have any histopathological report of previous biopsy material obtained by dilatation and curettage.

She was a middle aged women of thin built. Anaemia was present.

Abdominal examination did not reveal any lump or tenderness. On speculum examination, the vagina was normal. There was purulent discharge from the cervical os. No faecal discharge was found at the time of examination. On vaginal examination the uterus was anteverted, of normal size, firm and mobile; fornies were clear. During the stay in the Hospital faecal discharge was noticed from vagina two or three times. The patient was also examined under anaesthesia but no additional information was obtained. Fractional curettage was done and the material was sent for histopathological examination and diagnosed as endometrial carcinoma of uterus.

Laparotomy was performed on 25.1.1974. On opening the abdomen uterus was of normal size. Fallopian tubes and ovaries on both sides were normal and free from adhesions. Anterior and posterior surfaces of uterus were smooth but left cornu of the uterus was adherent with middle of the transverse colon (Fig. 1), the site of utero-transversecolic fistula (Fig. 2). There was no significant enlargement of lymph nodes of mesocolon. Pelvic lymph nodes wer also not enlarged. Pahhysterectomy with resection of affected part of the transverse colon was done. Colonic continuity was established by end to end anastomosis. Postoperatively she had severe secondary haemorrhage from the vault for which haemostatic stitches were applied. Vagina was packed and blood was transfused. The bleeding stopped eventually. She was discharged on 25th postoperative day. Patient is free from recurrence till the time of reporting of this case.

Biopsy Report: Uterus: Adenocarcinoma of endometrium infiltrating into adjacent bowel (Fig. 3). Cervix: Chronic cervicitis with ulceration. Fallopian tubes: Normal. Pieces of large bowel: Infiltrative carcinoma of uterus.

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