

UTERO-ABDOMINAL FISTULA FOLLOWING AN INDUCED ABORTION

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and

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After the implementation of the Medical Termination of Pregnancy Act 1972, most of the operations are being successfully and efficiently performed by qualified and experienced personnel in hygienic surroundings with negligible mortality and morbidity. But even now, instances of some innocent women falling prey at the hands of a few quacks with a very high rate of mortality and morbidity are not rare—mainly because these women from rural areas are unaware of the fact that abortion has been legalised.

Cutaneous fistula following gynaecological operations and menstrual fistula after caesarean section have been reported in the literature (Laffront and Ezes 1947; Falk and Tancer 1956; Youssef 1957; Kirkland and Chapel 1959; Bhaskar Rao 1961). But formulation of cutaneous fistulae leading to endometriosis without any surgical intervention is unusually rare. Here is such a case of utero-abdominal fistula as a sequelae of of an induced abortion.

Case Report:

Miss A. C., aged about 20 years, unmarried,

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was admitted to the hospital with chief complaints of purulent discharge from an abdominal wound for the last 12 months, except during the menstrual period—when there was oozing of blood through this point for about 10 months. She was also having continuous offensive vaginal discharge for about 1½ years. The patient stated that she had undergone an induced abortion by a quack about 1½ years back. The quack used a stick-like substance, probably the root of a tree, for the purpose of abortion at her 6th month of gestational period. Two days after the introduction of the stick, both the foetus and the placenta were expelled, but she was completely unaware of the existence of the stick. The puerperium was stormy with high rise of temperature and rigor, which was duly checked by antibiotics—but the offensive vaginal discharge continued. All the time she experienced some sort of stitching pain inside the vagina during defaecation and sit-down position. After about 6 months she noticed some bleb-like swelling on the right side of the abdomen, which burst with continuous purulent discharge.

Abdominal Examination: There was a small ulcer 4 cm in diameter situated 2" lateral and 2" below umbilicus, with an opening through which purulent discharge came out. (Fig. 1).

Menstrual History: Menarche at 14 years, with normal cycles. **Investigations:** Hb. 4.5 gram% and slight leucocytosis. Smear from the abdominal wound revealed growth of staphylococcus pyogenes. Drug sensitivity tests proved that she was sensitive to cloxacillin and cotrimoxazole.

Vaginal Examination: Due to the persistence of offensive vaginal discharge and as she was unmarried, pelvic examination was done under anaesthesia, when a stick-like structure was

seen coming out through the external os (Fig. 2). This stick was taken out with a little difficulty and the uterus was measured about 5½ in length. After the removal of the stick, there was leakage of purulent pus-like discharge through the cervical os. Diagnostic D and C was done and the material showed endometrial glands in the secretory phase, while stroma was oedematous and cellular. Biopsy from the abdominal wound disclosed fibrofatty tissue with focal collection of chronic inflammatory cells without any evidence of specific infective or neoplastic process. A rubber catheter was passed through the abdominal wound and methylene blue dye was introduced through the sinus tract; after a few minutes the vagina was stained with the dye.

Investigation—Hysterosalpingogram was decided upon, but as the patient was non-cooperative, urographin was introduced (through the catheter) into the abdominal wound. Antero-posterior and lateral sinogram showed fistulous communication between the uterus and the abdominal wound. (Figs 3 and 4). Thus the diagnosis of utero-abdominal fistula was confirmed.

Management—Laparotomy was done on the 3rd August 1977, when the uterus was found deviated to the right side and seemed to be adherent to the abdominal wound by some adhesion bands. It was bulky—about 14 weeks' size, the left ovary was normal but the tube showed hydrosalpinx. The fimbriated ends indicated slight depression due to the closure of the indrawn fimbriae (Fig. 5). The right tube and the right ovary could not be identified at first due to adhesions. On repeated attempts to separate the uterus from the anterior abdominal wall, it suddenly became free and an opening was detected near the right cornu. This opening appeared to be the inner end of the fistulous tract connecting the uterine cavity with the anterior abdominal wall; this was confirmed by passing a rubber catheter through the fistulous tract. (Fig. 6). Cornual opening was repaired by transfixation suture. The whole fistulous tract was excised by passing a probe and the incision was closed in layers. On histological examination, the excised portion of the tract close to the anterior abdominal wall showed scar endometriosis (Fig. 7).

Follow up—The patient attended the hospital on 23-12-77 and 2-2-78. Her menstruation started

in December 1977 and the cycles were regular. The abdominal wound was healthy, there being no leakage through the abdominal wall.

Discussion

Abdominal scar endometriosis may be due to direct implantation of endometrium from the cavity of the uterus, through some fistulous opening, onto the abdominal wall, or it may be due to some metaplasia. In the present case, direct implantation through the fistulous tract resulted in endometriosis.

On careful study of the case, many interesting features came to light:

1. The stick was introduced in a fairly big-sized uterus (24 weeks), when the uterus was close to the anterior abdominal wall, and for this reason—though the stick pierced through the uterus and was embedded in the anterior wall—the intestines escaped injury.

2. As the stick remained inside the uterus for a considerable length of time, there was a secondary infection causing collection of pus inside the fistulous tract and ultimately it burst through the anterior abdominal wall.

According to Kirkland and Chapel (1959), infection was the major factor for causing fistulae, while foreign body reaction was another factor in the formation of fistulae (Raja Gopalan and Alapat—1976). In the case cited above, the stick used for the induction of abortion was mainly responsible for the formation of the fistula as a foreign body reaction, pyometra and infection.

3. Finally, the endometrium from the uterus gradually crept in along the fistulous tract resulting in the periodic discharge of menstrual blood through the opening in the anterior abdominal wall and the process ultimately led to scar endometriosis. Growth of endometrium by contiguity has already been suggested

