V.V.F. IN ECTOPIC PREGNANCY

(WITH SHORT REVIEW OF THE LITERATURE)

by

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Introduction

In this paper we present a case of V.V.F. in a 22 year old woman who had an ectopic pregnancy in the broad ligament with arrested foetal growth. The mass consisting of arrested foetal growth had ulcerated through the anterior vaginal vault and was secondarily infected. The VVF was high and there was a stone in the bladder.

CASE REPORTS

Twenty-two years old woman was brought to Mary Wanless Hospital, on 8-1-1979 for foul smelling vaginal discharge associated with continuous dribling of urine for 1 year, fever with chills for 2 years and pain in the hypogastrium.

Obstetric and Menstrual History: She had been married for 7 years and had 2 full term normal home deliveries. Her cycles were regular at intervals of 28-30 days, and flow lasted for 3-4 days with average blood loss.

Present History: Following an amenorrhea of 3 months duration she suffered from dysuria and pain in the hypogastrium for past 2 years. No treatment was given. One morning she developed acute urinary retention. A gynaecologist was consulted who considered the possibility of an urinary infection with pregnancy as the cause of the condition and suggested D&C. Patient's bladder was drained by retension catheter and was put on antibiotics. The patient refused D&C and was discharged on urinary antiseptics.

She continued to have abdominal pain and dysuria. She also had fever with chills off and on. Later she developed a foul smelling vaginal discharge along with dribbling of urine and was examined by several doctors of varying skills and training. Practically a year later (that is 2 years after the original complaints) she was brought to this hospital.

On Examination: She was a thin person, was emaciated, appeared toxic and had a rapid pulse and respiratory rate. Her temperature was 102° F, blood pressure was 110/70 mm of Hg. There was foul smelling vaginal discharge. Abdominal examination showed fullness in the hypogastrium which was very tender on deep pressure. Due to severe pain she was uncooperative. Hence vaginal and speculum examinations were done under anaesthesia. Offensive vaginal discharge consisting of shagy shreds of mucus and bits of dead tissue protruding through upper vagina were seen. There was a V.V.F. which admitted 2 fingers easily and a stone was palpable in the bladder through this hole. There was also a separate mass about 4" in diameter, high up in the vagina. The anterior lip of the cervix was not identifiable separately in this shaggy mass. The posterior lip could be easily identified. This lump was firm and not freely mobile.

The most probable diagnosis considered was intra-uterine fibroid, prolapsing through the cervix with secondary infection, stone in the bladder and V.V.F.

Investigation: Hb was 70% presence of albumin in the urine, without sugar or bile and pus cells 4+, Oxalates crystals were present. Blood urea was 38 mg%. I.V.P. with poor function on both sides showed bilateral hydronephrosis and hydroureters. The left sided pathology was more marked. Prior to surgery her general health was improved with high caloric and protein diet, Vitamins and hematinics and urinary infection was controlled with antibiotics.

Operation

A midline suprapubic incision was made. When the peritoneal cavity was opened a mass

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was visible which was separate from the uterus (which was small). The mass was anterior to the lower uterine segment and cervix and extended in the left broad legament and had pushed the bladder to the right and anteriorly. The plane of cleavage for the dissection of this mass was not available. Therefore, it was decided to remove this mass transvaginally. The peritoneal cavity was closed to prevent peritoneal contamination. A suprapubic cystostomy was done to remove the stone. Transvesical repair of the VVF was carried out and the bladder was drained by suprapubic catheter. Later the lump anterior to the uterus and protruding through the vagina was removed transvaginally and the cavity was packed.

Postoperatively the patient had a stormy postoperative period with a swinging temperature and unstable blood pressure. The sepsis was controlled with broad spectrum antibiotics, I.V. fluids and blood transfusion. Later she was given sulpha drugs for urinary infection but she developed an adverse reaction with severe skin rashes. This prolonged her hospital stay. Patient was discharged on 9-3-78.

Conclusion

Ectopic pregnancy with arrested foetal growth and a bladder stone causing a VVF is recorded. A successful transvesical repair of the VVF was done in this patient, a changing etiology in the causation of the VVF is stated. Post radiation VVF is the commonest cause in our series. Sigmoid conduit as described here has given us good results.