POST-CAESARIAN UTERO-VESICAL FISTULA WITH STONE FORMATION

(A Case Report)

by

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The patient described here had an utero-vesical fistula which had developed in the immediate post-operative period. The unique feature of this fistula was that it was an apparent complication of caesarean section. Two stones of various sizes were seen stringing on a nylon thread which were removed during the operation for repair of the fistula.

CASE REPORT

The patient 25 years old, complained of continuous dribling of urine for the last 9½ months after caesarean section. She also complained of pain in the lower abdomen and occasional fever for the last 3-4 months.

Her previous menstrual cycles were normal. She was in the lactational amenorrhea after childbirth. The obstetric history was contributory. She was a primipara with history of full term caesarian section at Mokamah hospital for severe antepartum haemorrhage.

Abdominal examination revealed a right paramedian scar and supra-pubic tenderness. No lump was, however, palpable. On local examination, the vulva was excoriated. Speculum examination showed the vaginal mucosa to be healthy and normal, the urine was coming from inside the cervical canal through the cervical os.

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Investigation

Hb was 74%. Total and differential W.B.C. routine urine and stool examination did not reveal any abnormality. B.Coli were isolated on culture examination of urine.

Therefore a plain X'ray of abdomen and pelvis was taken and it showed a radio opaque shadow in the retropubic region (Fig. I) Methelyne blue test was carried out and the stained urine was seen coming from the cervical os.

Intravenous pyelography was also done which showed the normal kidney on both sides and the dye finding its way from the bladder into the uterus (unfortunately photograph of this X-ray plate could not be taken).

Pre-operatively the patient was put on Septran two tablets twice daily for 7 days.

Laparotomy finding

Abdomen was opened through the previous right paramedian scar under G.A. on 15-2-76. The uterus was normal in size, adenexae were also normal. Utero-vesical pouch of peritoneum was opened. Small stone of the size 2 cm. x 1 cm. was felt lying in this area. While attempts was being made to take out this stone intact, a nylon thread was seen spreading from this stone to inside of the bladder where another stone of bigger size about 3 cm. x 2 cm. was felt and delivered intact on the thread (Fig. 2).

After the stones were taken out the fistulous opening in the base of bladder and in uterus at its lower segment now could be visualised. There was moderate scarring around the fistula and the vesical hole was easily accessible. The tissues available for closure of fistula were adequate. The fibrous tissue around the fistula

were disected out. The ureteric openings were seen with normal reflux. Fistula was repaired by extravesical approach with atraumatic chromic catgut no. 00 in two layers taking care for the ureteric opening. The hole in the uterus was closed by chronic catgut No. I. The utero-vesical pouch was closed.

In the postoperative period the bladder was drained continuously with a Foley's catheter for 14 days. The patient was put on Terramycin 100 mgm. I.M. 8 hourly. Abdominal stitches were removed on 10th post-operative day and the wound was healthy. On 14th day, catheter was removed and the patient was encouraged to empty the bladder frequently, till the bladder tone was regained fully (for about 7 days).

Discussions

The interesting features of the present case was that the bladder was injured during caesearean section and base of bladder was communicating with the uterus. Perhaps an attempt was made for its repair by nylon suture, unfortunately it did not heal and patient developed true incontinance, with development of stones. These stones were removed and the fistula in the bladder base was repaired with chromic catgut (No. 00).

An important point is the after care. It is essential to keep the bladder empty by continuous suction drainage for 2-3 weeks. In the present case it was arranged through the urethra but few authors prefer to drain it by suprapubic cystostomy.

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See Figs. on Art Paper V