ABDOMINO-VAGINAL FISTULA FOLLOWING HOME DELIVERY

(A Case Report)

by

NIRMAL GULATI,* M.D.

With improved antenatal and intranatal care there has been a decline in the incidence of difficult traumatic vaginal deliveries and associated complications. However, in this part of the country where majority of patients hail from rural areas and most of the deliveries are still attended by local dais, one encounters sequelae of obstructed labour like rupture uterus, vesico-vaginal fistulae etc. rather frequently. We encountered a very unusual case of infected cervical and vaginal tear extending upto lateral pelvic wall following spontaneous home delivery. Malodorous pus was seen draining from midinguinal region, skin over which had sloughed off, as well as from vagina and there was an irregular crooked fistulous communication between left lateral vaginal wall and right inguinal region.

CASE REPORT

Mrs. U., 20 years, married for 3 years, Pl+0 was admitted for the first time on 18th October 1978 as emergency to Medical College Hospital, Rohtak (Haryana) for pain in lower abdomen, fever and purulent vaginal discharge for one week. She had full term normal delivery at home conducted by dai on 4th October, 1978. Labour lasted for 13 hours and resulted in the birth of fresh stillborn female baby of average size without any gross congenital malformations. Placenta was expressed out after 5 minutes and there was no post-partum hemorrhage.

On third day of delivery, patient had an episode of giddiness while straining for micturition and on 7th day, she had fever alongwith pain in lower abdomen more on left side with retention urine. She was hospitalised in a private nursing home where she was catheterised and frank purulent vaginal discharge was noted at the time of pelvic examination. She was treated for one week with I/V fluids, injections and some vaginal operative procedure was done and drainage tube was left in. She noted a swelling in right iliac fossa, which burst and discharged purulent material on the day of admission.

Abdominal examination revealed an abscess pointing in the right iliac fossa and pus discharge with air bubbles escaping through it.

Vaginal examination:

There was a deep tear in the vagina extending from left lateral wall of cervix upto lateral pelvic wall. Os closed. Size of uterus could not be made out due to tenderness. There was fullness in right fornix extending almost upto right iliac fossa. On speculum examination, vagina was full of extremely malodorous pus.

Investigations

Pus culture from vagina yielded staph. aureus and pseudomonas aerogenosa sensitive to chloromycetin and ampicillin. Pus from abscess in right iliac fossa on culture revealed staph. albus sensitive to all antibiotics. 3½" x 1½" skin over right iliac fossa parallel to right inguinal ligament sloughed off exposing unhealthy necrosed tissues underneath upto deep innguinal ring medially. Furacin dressings at this site were also carried out. During vaginal and in-

*Reader, Department of Obstetrics and Gynaecology, Medical College Hospital, Rohtak (Haryana).

Accepted for publication on 14-12-82.

guinal region dressing, it was found that antiseptic solution used for abdominal wound used to escape from vagina including the dressing gauze. Examination under anaesthesia in operation theatre on 18-11-1978 revealed a deep vaginal tear extending from left side of cervix involving vagina on left lateral side through which a finger could be passed and could be approximated to a probe passed from abdominal opening at the deep inguinal ring (Fig. 1). Thus a diagnosis of abdomino-vaginal fistula was made and tract was visualised radiologically by injecting urograffin by passing a P.V.C. canula from above as well as from below when infection was under control (Fig. 1 and 2).

Patient was treated conservatively by systemic antibiotics as well as local dressings. Abdominal as well as vaginal wound healed and patient was discharged on 22-12-1978 in good condition.

She came for follow up on 10th January 1979 and on examination, there was a scar parallel to right inguinal ligament 3½" long and 1½" broad. Pelvic examination revealed cervix deviated to left, Ut. A.V.N. size. There was scarring in left fornix and a small chink of depression at the site of earlier tear was felt and seen on speculum examination.

To our surprise, when patient visited on 9th May, 1979, she was 8 weeks pregnant. She came for antenatal check up regularly. She developed right sided indirect inguinal hernia with ring nearly 2½" in diameter. At 37 weeks of pregnancy on 28-11-1979 she was admitted with labour pains. Abdominal examination revealed 36 weeks pregnancy with ROA with good foetal heart sounds. Pelvis was normal except for minimal scarring and left lateral cervical tear. She delivered normally on 28-11-1979 at 3.05 P.M. an alive male baby weighing 2.8 kgms. Mother and baby were discharged in good condition on 5-12-1979 with adice to have repair of hernia at 3 months later.

See Fig. on Art Paper II