SALPINGO-SIGMOID COLON FISTULA

(A Case Report)

by

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Of all genital tract fistulae genito-urinary fistula is the commonest. Genito-intestinal fistulae are rare ones and we came across one such rare fistula.

CASE REPORT

Mrs. R.N., 28 years Hindu female was admitted in Manicktala E.S.I. Hospital with complaints of Secondary Infertility, temperature and backache for 5 months.

Past History

22-1-73 Marriage

19-3-73 Induced Abortion at 12 weeks followed by Septic Abortion treated conservatively in R. G. Kar Medical College, Calcutta.

5-1-75 Appendecectomy done for Chr. appendicitis. Adhesion on tubal area seen, salpingolysis done followed by hydrotubation with Dexamethasone, Streptomycin and normal saline biweekly x 10.

After 3 months pain and temperature.

March 1975 hysterosalpingography done—Right sided T.O. Mass.

Advised hydrotubation with the previous drugs once a month on 10th day of menstruation.

October 1978 H.S.G. repeated—Right sided T.O. Mass, Left tube blocked.

On Examination

Anaemia + Tenderness over Right Iliac Fossa.

Internal Examination

Uterus—Normal Size, mid Position, restricted mobility, Rt. Fornix—Big tender T.O. Mass. Lt. Fornix, thickened, tender. P.O.D.—free. Provisional diagnosis—Chronic pelvic inflammation (?T.B.).

Investigations

1. Curettage done premenstrually. Insufflation—Positive (details—see Discussion). Endometrium showed mild secretory changes, no evidence of tubercular endometritis.

2. H.S.G. done Post-menstrually on 22-2-80. Uterus—normal in shape and size. Lt. tube—Blocked. Rt. tube—Slight spillage present. Salpingo—rectal fistula (see X-Ray Plate).

(On inquiry Patient gave the history of bleeding per rectum during periods for last 9 months as well as whitish discharge in bulk per rectum at intervals. She did not give any history of flatus or faeculent discharge per vaginum).

3. Dye Test on 30-5-80. Sterile methylene blue was introduced insided the uterine cavity through H.S.G. canula under G.A. Proctoscopy revealed dye coming from a point beyond the limit of proctoscope. Conclusion—Fistula above recto-sigmoid junction.

Laparotomy was done on 6-6-80 under G.A. Abdomen opened by infraumbilical midline incision. There were many omental adhesions,

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bladder was drawn up infront and above the uterus. After careful dissection, traction was given to the left round Ligament which exposed the tubo-ovarian-intestinal mass. During dissection of individual structures frank pus came out from the accidental punctured site in the retort shaped thick walled distended tube. Ovarian cyst containing old blood was also present on right side. Fistulous communication between right sided pyosalpinx and recto-sigmoid junction was dissected out. Right sided salpingo-Ovariotomy was done. The opening in the large intestine was repaired in layers.

On left side a smaller tubo-ovarian-intestinal mass was present. Individual structures were dissected revealing thickened tube, the fimbrial end of which could not be detected. The small intestine was intact and the ovary had evidence of peri-oophoritis.

Closure of abdomen was done after haemostasis and toileting of abdomen.

Bacteriological Report of Pus

E. coli sensitive to Gentamycin and Kanamycin.

Post-operative Period

She was treated with Gentamycin. Post-operative Period was uneventful.

Follow Up

She came after 1 year with the complaints of periodic bleeding per rectum as well as per vaginum, occasional discharge of pus per rectum. General health of the patient was improved.

Discussion

Salpingo-intestinal fistula is mostly seen in cases of spontaneous rupture of pyosalpinx into the intestine. Bacteriology generally reveals tuberculosis but in the present case it was *E. coli.*

Discharge of menstrual blood per rectum which was present in this case is more commonly found in utero-intestinal fistula.

Insufflation Test which was found to be positive may be 'false positive' resulting from passage of air into the intestine through the Fistulous Tract.

See Fig. on Art Paper IX