An unusual case of recurrent faecal fistula with pregnancy

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Patient, 25 years old was admitted in Dayanand Medical College and Hospital, Ludhiana on 18.11.1995 with a history of amenorrhoea 36 weeks. LSCS was attempted for breech presentation in a private nursing home resulting in bladder and gut injury. Patient's abdomen was closed and referred to this hospital.

Past history
2¼ years back she had a laparotomy for an ovarian cyst at a civil hospital, where she developed faecal fistula following gut injury. Patient was treated in this hospital and recovered completely.

Menstrual history
Menarche: 17 years, 4/28 days regular, painless, moderate.

Obstetric history
G3 P1 A1

1. 5 years female delivered at home. Died after 8 weeks because of gastroenteritis. Patient had D&C because of retained placental bits in this hospital 6 weeks after delivery.
2. Hysterotomy was done at 20 weeks of gestation for failed II trimester abortion 4½ years back.

On examination
Patient was anaemic; Pulse rate: 128/min.; BP: 130/80 mmHg.; No oedema feet; Heart: NAD; Lungs: clear.
P/A: Abdomen was distended; Rigidity and guarding.
On opening the dressing faecal matter was coming out of the stitch line. Bowel sounds were absent. Patient was taken up for laparotomy.

Investigations
Hb. 10.9 gms.; Total WBC count 6,000/cmm.
RFT: Normal.

Operative notes
Under general anaesthesia, sutures of the previous abdominal incision were cut. On opening the abdomen, gut was adherent to abdominal wall and faecal matter was coming out of the cut loops of gut. Gut was separated from abdominal wall.

Bladder was adherent to the uterus. Stitches were seen on the anterior wall of bladder. Bladder was reflected down away from the anterior wall of uterus.

Classical C.S. was done. Female alive baby was extracted as breech. Cord was clamped and cut. APGAR score 3/10, 7/10; weight: 2.07 kg. Uterus was closed in layers and complete haemostasis obtained. Left fallopian tube was ligated. Right tube could not be visualised.

After classical C.S., adherent gut loops were mobilised. There were multiple perforations and gross adhesions in the ileum and jejunum. Adhesions were separated. Clear small intestine of about 2 feet could be dissected. Ileo-transverse anastomosis was performed in two layers after resecting the adherent and multiple perforated ileum and ascending colon.

Bladder repair performed after leaving 16 F Foley's catheter and by suturing the bladder wall. Drain left in right pelvic and Morrison's space and in left paracolic gutter.

Incision closed with 1:0 proline with interrupted sutures in single layer and subcutaneous tissue closed with 2.0 catgut, skin was left open. Sterile dressing was done.

Post operative recovery was uneventful. Healthy mother and baby discharged on 20th day.