Faecal fistula following septic abortion. (A case report.)

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Mrs. Lila Halder P_2 + O, aged 30 years came to Chittaranjan Seva Sadan on 1.3.97 with severe bleeding P.V. for a day. She had neither amenorrhoea nor menstrual irregularity before. She gave history of CuT insertion 3 years back, the thread of which she was unable to feel for last 1 week. She attended OPD earlier with this complaint when USG revealed a viable pregnancy of 18-20 weeks with CuT in situ. She was having a low grade fever for last 7 days with frequency of micturation, without abdominal pain, dysuria, or foul smelling discharge.

After admission, cuT was removed, the thread of which was seen dangling through the os. Uterus at the time of examination was of 20 weeks size. On 2.3.97 morning there was spontaneous complete abortion. In the evening she complained of abdominal pain with temperature and antibiotics, (Ampicillin, Metronidazole) and symptomatic treatment were initiated. Next morning she was having severe abdominal pain with vomiting, vaginal bleeding and oliguria. She was also having pallor, hurried respiration and cold clammy extremeties, BP 90/60, Pulse 110p.m. Abdomen was distended and tender; Shifting dullness – present, I.P.S.-absent, muscle guard = +. There was vaginal bleeding along with foul smelling, dark brown discharge, OS-open, uterus could not be well delineated. P.O.D. appeared full signifying peritonitis. Patient received IV fluid, anti-biotics (Taxim, Metrogyl, Amikacin), Ryle's tube suction, Injection Hydrocortisone and continuous catheterisation etc. Quadripuncture showed frank pus in abdominal cavity. Conservative treatment for 1 week continued with higher antibiotics. (Amikacin, Metrogyl). She received 2 bottles of blood. Reports of cervical and high vaginal swab showed growth of streptococcus pyogenus. I.V fluid and Ryle's tube suction discontinued on 7/3/97, when abdominal distension diminished, peristaltic sounds returned and liquid diet was started with continuation of parenteral antibiotics. With the above mentioned regimen though fever subsided, persistent abdominal distension, tachycardia, tachypnoea, frequent loose motions and mild dehydration persisted. A decision for drainage of pus was taken on 10/3/97 with blood ready at hand. Posterior colpotomy was attempted but could not be performed, so exploratory laparotomy under G.A. was undertaken. During laparotomy, peritoneum was found to be thickned and fibrosed. Pus welled out and abdominal wall was separated from adhesions. Abdominal toileting was done with normal saline and Metrogyl. Drain with corrugated rubber sheet was left on both the flanks. Abdomen was closed with tension sutures. Antibiotics (Ampicillin, cloxacillin), blood transfusion, steroids were given. Dressings over the drains were changed regularly. Slowly peristaltic sounds started returning. Urine output was adequate and patient passed flatus. On 13/3/97 oral feeding started, but patient had not yet passed stool. On 4th postoperative day greenish discharge without any foul smell was seen coming out in copious quantities from drain area. The materials were sent for microscopical and biochemical examinations. Reports – Faeces present with bile pigment and large number of pus cells. From 7th postoperative day identical materials was seen coming out through the stitch line, also surgical opinion was sought for and accordingly patient was treated with IV fluid, NPM, Antibiotics (Ampicillin, cloxacillin, Gentamycin and metrogyl & Dulcolax suppositors on alternate days. There was local excoriation of areas surrounding the drain and stitch line. Drains from L.I.F and R.I.F. were removed and foley's catheter was introduced, so that no spillage would occur. This conservative treatment was continued and gradually oral feeding was allowed, alter 7 days. Her general condition started improving and spillage coming through the drain area was slowly reduced and arrested. She was put on oral medication and discharged after one month.