

## Ascaris Lumbaricoides from Uterus – A Unique Presentation of a Rare Tubocaecal Fistula

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### Introduction

Leaving aside a rectovaginal fistula, fistulous communication between the genital tract and the intestine are rare. Tubo intestinal fistulae are much rarer compared to utero intestinal. About 21 cases of tubo intestinal fistulae have been reported in this century. Out of all tubo intestinal fistulae, the commonest reported is tubo sigmoid which is explainable due to the close proximity of the left fallopian tube and the sigmoid as compared to the right tube and caecum. Only five cases of tubocaecal / appendicular fistulae have been reported.

The symptomatology of these fistulae are often non-specific, the commonest being a lower abdominal pain. Purulent diarrhoea, vaginal feculent discharge or passage of flatus may be the other symptoms. It may also be detected during a routine HSG performed during infertility work up.

Hereby, we report a rare case of tubo caecal fistula resulting from puerperal sepsis with a unique presentation of expelling *Ascaris Lumbricoides* through the cervix uteri.

A 26 year old woman, P3L2 was admitted with the complaints of pain in right lower quadrant of abdomen for three weeks. Patient had a full term vaginal delivery at home one month ago and developed high grade fever accompanied by pain in lower abdomen from the 3<sup>rd</sup> postpartum day. She was treated with antibiotics for puerperal sepsis in another hospital on an outpatient basis, with which the fever subsided, but the pain in abdomen persisted. From the 10<sup>th</sup> postpartum day, she started passing round worms per vaginum. She had no urinary complaints and there was no history of passage

of stools per vaginum or purulent diarrhoea. Findings on general physical examination unremarkable. Her abdominal examination revealed minimal tenderness in the right iliac fossa with no guarding or rigidity. There was no free fluid in the abdomen and the bowel sounds were normal. Per speculum examination revealed a healthy vagina and a congested and dilated cervix through which multiple live round worms were seen wriggling out (Fig. 1). There was no fecal matter or fistulous opening seen in the vagina. On pelvic examination uterus was normal size, retroverted, deviated to the right side, with restricted mobility. There was minimal thickening and tenderness in the right fornix and the left fornix was free. No adenexal mass was palpable on either side. Rectal examination confirmed these findings and no fullness in the pouch of Douglas was detected.



Fig 1

With the clinical diagnosis of an entero-uterine fistula and associated pelvic inflammation, patient was put on broad spectrum antibiotics alongwith deworming with Pyrental palmoate. Pelvic ultrasonography revealed multiple gut loops around the uterus which was normal except for bright endometrial echoes. Left ovary was normal but right ovary could not be visualized. A barium enema and a barium meal follow through were both normal. Hysterosalpinogram (HSG) revealed a normal uterus and a normal left fallopian tube with free spill. The right tube was dilated at the ampullary region with a long narrow fistulous tract communicating with the cecum (Fig.2 ), thereby diagnosing the case to be one of tubo-caecal fistula. Her haemogram showed a raised ESR (60mm/ hr.) and mild polymorphonuclear leukocytosis (15,000/cu.mm). Her X-ray chest was normal and Mantoux was negative.

The patient was advised surgery but she refused as she had become symptom free within a week of medical therapy. Even a repeat HSG 6 wks, later, to establish the status of the fistula was refused by the patient as she had no complaints. She was followed up for 6 months during which she remained asymptomatic.

In tropical country like India, where pelvic tuberculosis is not infrequently encountered, cases of postpartum and post abortal sepsis are fairly common and round worm infestation is endemic, it is certainly an enigma-an unexplainable law of nature -why perhaps for the first time ever, *Ascaris Lumbricoides* negotiating the tubal lumen and even the interstitial portion of tube which measures only 1mm in diameter to enter the uterine cavity and find a way out through the cervical os.



Fig 2