Tubo-Cutaneous Fistula – A Case Report

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B.J. 35 years old Para 3, reported to hospital with complaints of a discharging sinus in left iliac fossa for the last 10 months. She had no menstrual complaint. She had undergone abdominal sterilization in rural hospital 13 years ago. Her past history revealed that she had been treated for pelvic inflammatory disease 7 years ago, following which she had developed an abscess in left iliac fossa, which had been drained followed by antiseptic dressings for about a month, after which she had improved. One year back she again developed a pea size tender swelling at the site of previous incision and drainage. It gradually increased in size and was fluctuant and tender and ruptured spontaneously after 2 months. There was history of spiky, intermittent fever during this time. Since then she had been discharging pus from it off and on.

On examination the patient was thinly built with mild anaemia and no abnormality was detected on general physical examination, cardiovascular system, respiratory system and on per abdomen examination, except for localized tenderness around the discharging sinus. On pelvic examination cervix and vagina were healthy, uterus was acutely anteverted, normal in size, firm nontender with restricted mobility. Left fornix was slightly tender and thickened, right fornix and pouch of Douglas were clear. She was referred to surgery for the discharging sinus. Her routine blood examination and bio-chemistry were within normal limit, x-ray chest was clear, pus from the discharging sinus was sterile on culture. A sinogram was done, which showed a tubular tract ending abruptly. A presumptive diagnosis of Koch's abdomen with a discharging peritoneal fistula was kept in mind and exploratory laparotomy was planned. To our surprise no evidence of Koch's abdomen was found and all the viscera were apparently normal. The left ovary and tube were forming a tubo ovarian mass about 5cm x 4cm and were adherent to peritoneal surface at the site of discharging sinus. Uterus was of normal size forming flimsy adhesions with omentum, right ovary and tube. Both the tubes showed tubectomy marks, left salpingo-opherectomy was done and about 5-10CC of pus was found in the left tube distal to the tubectomy site. Peritoneal toileting was done and abdomen was closed in layers. The tube and ovary were subjected to histopathology which showed evidence of chronic inflammation with no granuloma formation. The patient left the hospital on the 8th post operative day in good health.

Retrospectively on analysis it appears that the abscess which was drained seven years back was a pyogenic tubo-ovarian abscess pointing towards left iliac fossa which had lead to the formation of this tubo cutaneous fistula.