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Post MTP Recto – Uterine Fistula – A Case Report

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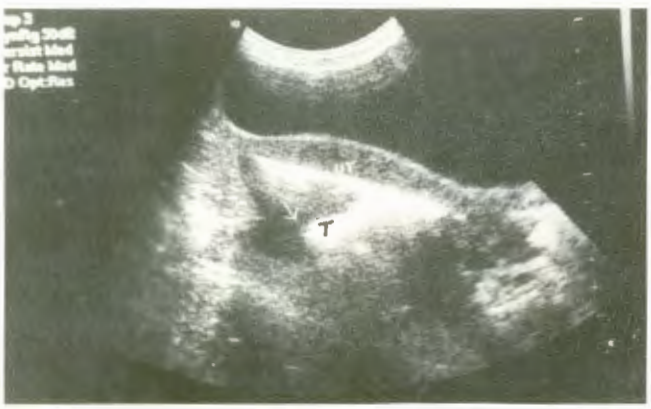
R.G. / 24 / F presented to us with complaints of passing faecal matter vaginally. She also had abdominal pain and had fever with chills once 2 days back. She gave h/o medical termination of pregnancy 8 days back at a private nursing home. She was dischrged 24 hrs after the procedure.

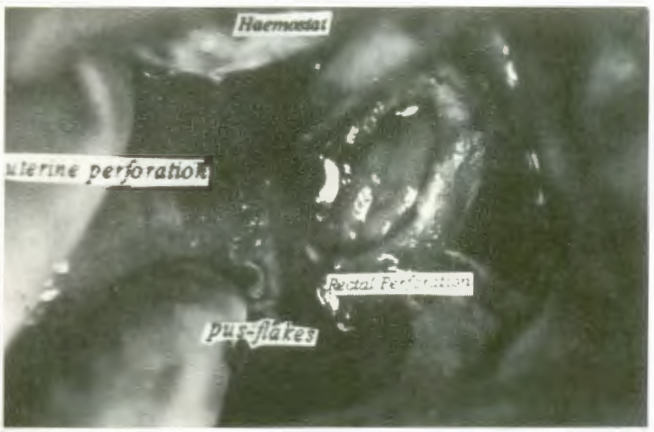
Clinical Examination revealed young female, looking ill, febrile, pulse 120/min. She had tenderness all over the abdomen. P.S./P.V. exam. revealed cervix open, faecal matter coming through the cervix, tenderness in posterior fornix, uterus difficult to make out separately.



Photograph 1: USG Film - Showing Fistulous Track Between Uterine Cavity and Rectum

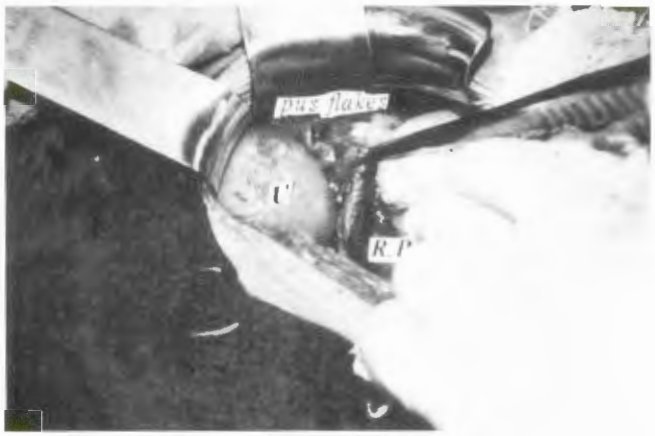
Provisional diagnosis of recto-uterine fistula with pelvic peritonitis was thought of and patient was investigated as follows:
Hb-10gm.%, TLC – 12000/mm3, DLC: P-79%, L-15%, E-4%, M-2.
Urine (R) – WNL, USG ABD. – Revealed dilated small bowel loops, free gas in uterine cavity and few products of conception in pouch of douglas. A fistulous track also could be seen between uterine cavity and rectum. (Photograph 1).

Photograph 2: Showing rectal perforation
R.P. = Rectal Perforation



Photograph 3: Showing Large Rectal Perforation and Pus flakes

She was subjected to exploratory laparotomy under G.A. by infraumbilical midline incision. It revealed oedematous, congested small bowel loops adherent to posterior wall of uterus, 10ml of foul smelling infective fluid in peritoneal cavity. Gentle separation of small bowel loops revealed perforation of 1 cm size, irregular in outline on posterior wall of uterus and a large perforation of 1 rupee coin size over anterior wall of upper 1/3 of rectum (Photographs 2 & 3). Large amount of pus flakes & necrotic tissue was present in pouch of douglas (Photograph 4). The adherent small bowel loops showed 3 small perforations which were close to each other & interventing small bowel was oedematous & congested.



Photograph 4: Shows PUS flakes in Pouch of Doughlas

Thorough abdominal wash was given. Perforation of the uterus was closed easily but that of rectum was closed with difficulty after debridement of necrotic edges. The small bowel loop with perforations was resected and end to end anastomosis was done. Bil. tubal ligation was carried out with consent of the husband, as the couple had two female issues (Both FTND). Appendectomy was also done and temporary (L) sigmoid loop colostomy was done to protect the rectal closure and prevent faecal fistula formation. Incision was closed in layers. She was given parenteral fluids for 4 days along with injectable III generation cephalosporins and metronidazole. She had nice recovery and was discharged on 10th post operative day with well functioning colostomy and nicely healed wound.

Her colostomy was closed after 2 months under spinal anaesthesia. The second hospital stay was also uneventful. At present she is enjoying her family life very well.