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Primary Peritonitis – Case Report

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Primary peritonitis is a rare condition occurring, by definition, in patients without any underlying cause such as perforated viscus, preexisting ascitis or nephrosis.

We are reporting a case of primary peritonitis detected incidentally in a patient with the third degree prolapse. Review of the world literature shows predilection for women to have this condition. The entry site could be asymptomatic genital tract colonization Shock or toxic shock syndrome often accompany the abdominal findings.[Moschowitz et al 2000].

Mrs. MP 28 year old married house-wife belonging to a low socioeconomic Hindu family was admitted to our institution with 3rd degree uterine descent with chief complaints of something coming out at vulva and leucorrhoea since 6 yrs. Her menstrual cycles were regular and normal. She was para-2; Living-2; followed by M.T.P. with laparoscopic TL done 6 months back.

O/E:- Her vitals were normal. She had 3rd degree uterine descent with moderate cystocele and rectocele. The UCL was 3.5 inches. Uterus was retroverted and normal size, smooth, firm, mobile. She was advised uterosacral advancement with A-P repair. Blood investigations were within normal limits with Hb of 12 gms. Total count – 7200 [P-68, L-24, E-06, M-02]; E.S.R, — 40mm/hr. Urine examination was normal. All other biochemical parameters, X-Ray-Chest and USG pelvis were normal. She was V.D.R.L. and H.I.V. negative with blood group B-Rh- Neg.

On 19/10/2000 she was posted for uterosacral advancement but on opening the pouch of Douglas around 200cc of pus drained out, so the procedure was abandoned and instead exploratory laparotomy was done to find out the source of the pus. The laparotomy findings showed normal sized uterus with apparently healthy looking tubes. Right ovary was normal and left ovary was enlarged with multiple follicles. Bowels, omentum and the entire peritoneal cavity was normal. A drain was kept in the posterior pouch using a 'Malecots' catheter (see figure). The abdomen was closed after giving a good peritoneal lavage. Peritoneal lavage given after exploration ensures better healing.(Krukowski and Matheson 1983). Post operatively the patient was started on Cefotaxime, Cefixime, Gentamycin and Flagyl. Drain was removed on day 5 and sutures were removed on day-7. We started the patient on 4-drug. A.K. [constituting

Figure showing Malecolt's Catheter used as a drain in Pouch of Doughlas

Rifampicin, INH, Ethambutal and Pyrazinamid] in view of raised serum Adenosine deaminase levels. Pus SCASTS (Smear Culture and Antibiotic Sensitivity Tests) report came as no growth with occasional pus cells. Patient was discharged on day-8.

Primary peritonitis refers to inflammation of peritoneal cavity without documented source of infection. The incidence quoted is around 4 to 5% [Karaguzel et all 1998]. It is more common in female, children and immunocompromised patients. Primary peritonitis is also referred to as spontaneous bacterial peritonitis and the most common organisms responsible are, Hemolytic streptococci, Pneumococci, haemophilus, E-coli, Klebsiella, Clostridium welchi and Staphylococci in that order.

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