



Uterocutaneous fistula

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Introduction

A fistula is an abnormal communication between two epithelial surfaces. Fistulas are usually lined by granulation tissue but can get epithelialized. Gynecologists are familiar with fistulas involving the urinary tract and the genital tract. But uterocutaneous fistula is rare. One such case which occurred following laparoscopy and laparotomy for paraovarian cyst is reported.

Case report

A 29 year old P₂L₂ sterilized woman was admitted from the outpatient clinic on 21st May, 2003 for bleeding through the tubectomy scar site during menstrual period for the last 3 years and serous discharge from the same site off and on. There was no history of any mass or cyclical pain at that site. Her menstrual cycles were 2-3/90-120 days with moderate flow and were irregular since menarche. She gave a history of two previous normal deliveries. In February 1996, she underwent puerperal sterilization on the 5th postnatal day after her second delivery. She developed wound sepsis and subsequently developed a serous discharge off and on from the sinus at the scar site. In December 1999 she underwent diagnostic laparoscopy for lower abdominal pain at which she was diagnosed to have right paraovarian cyst. Because of the dense adhesions of the cyst to the anterior abdominal wall,

laparotomy was done followed by removal of the cyst. Six months after laparotomy she started discharging menstrual blood through the tubectomy scar sinus site. Her general physical examination was unremarkable. On abdominal examination there were two abdominal scars, a low transverse scar in suprapubic region, which was healthy. Another scar about 5 cm above that had a sinus opening of 5 mm with blood seen coming through that sinus. She was menstruating at that time. On speculum examination, the cervix and vagina were healthy looking. On vaginal examination the uterus was anteverted, normal sized, and mobile. The fornices were free. After stoppage of her period, methylene blue was injected transcervically and it was seen coming through the abdominal scar site. Surgery was decided upon and performed on 26th May, 2003. Just before surgery, methylene blue was again injected transcervically to delineate the fistulous tract (Figure 1). While opening the abdomen, the cecum which



Figure 1. Photograph showing Methylene blue test, dye is being injected transcervically, seen coming out of the fistulous opening on the abdominal scar site.

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was adherent to the anterior abdominal wall and to the fistulous tract was injured. The fistulous tract stained with the dye (Figure 2) was excised. The rent in the uterine fundus was repaired with 1-0 vicryl. Bowel injury was repaired by resection and anastomosis. Abdomen was closed in layers after keeping a drain. The drain was removed after 48 hours. She had an uneventful postoperative period. The wound healed well. She was discharged on 10th June, 2003. Histopathology of the fistulous tract showed fibromuscular tissue and the tract lined by granulation tissue with no specific inflammation. One edge of the excised tissue showed a muscular coat of intestine. There was no evidence of endometriosis or tuberculosis.



Figure 2. Photograph showing stained fistulous tract after opening it.

Discussion

A number of cases of uterocutaneous fistula are reported in the literature. Majority of these fistulas followed classical cesarean section. The decrease in the incidence of uteroabdominal fistula may reasonably be attributed to marked decrease in the frequency of that type of operation in modern obstetrics¹. Jain et al² reported uterocutaneous fistula following lower segment cesarean section. Gupta et al³ reported uterocutaneous fistula which developed following septic abortion induced by laminaria tent insertion in the cervix. In their case, fistula developed subsequently at the drainage site on the abdomen³. In most of the reported cases infection was a complicating factor. In our case the patient had a sinus present in the tubectomy scar site, which developed following wound sepsis. She might have developed uterine perforation following uterine manipulation during diagnostic laparoscopy. Since there were dense adhesions between the uterus and abdominal wall, the sinus in the abdominal wall got communicated with the perforation site in the uterus leading to the formation of uterocutaneous fistula. Most uterocutaneous fistulas originate from some type of infective process that disrupts the continuity of tissues involved. Once a fistula is diagnosed, prompt excision of the fistulous tract is required.

References

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