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CASE REPORT

Uterocutaneous fistula - post cesarean section

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Abstract

A uterocutaneous fistula is a rare clinical presentation that usually occurs following caesarean section and other pelvic operations. Only a few articles have been published discussing its treatments[(1)]. We describe a patient with successful surgical management[(1)]. We have described a patient of 21 years old P1L1 post LSCS 9 months back had presented to our OPD with a small opening in the infraumblical region since 2 months. On examination there were multiple serous discharge at LSCS scar site. It was surgically treated by exploratory laparotomy with complete fistulous tract excision. Inspite of the uncommon occurrence of uterocutaneous fistula, it should always be considered following cesearean section or any pelvic operations**.** It is a rare and late complication following LSCS or any other pelvic operation. Needs proper investigation and timely medical and surgical management.

Keywords: Uterine diseases; Cesarean section; Pregnancy; LSCS

Introduction

Most uterine fistulae are between the uterus and the bowel or bladder[(1)]. Uterocutaneous fistula is a rare condition and there is no sufficient evidence based treatment modality available for uterocutaneous fistulas caused by injury, surgery, secondary to infection or inflammation. A few cases has been reported after septic abortion, pelvic abscess, secondary abdominal pregnancy, uterovaginal malformation and migration of an intrauterine device.

Case Report

A-21-years old woman P1L1 with h/o cesarean section 9months back. Referred to BMCRH with a small opening in infra umbilical region since 2 months which was a bleb initially and got ruptured later to the present size. Multiple serous discharge present at LSCS scar site which was on and off since 9 months. She got treated for the discharge prior to the referral. During her Antenatal period, she was diagnosed PIH and hypothyroidism and was on treatment for the same.

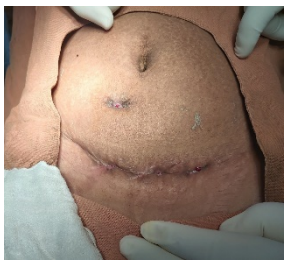

Fig 1. Showing Fistulaous openind and LSCS scar with multiple sinuses

Examination

Mild tenderness present and opening present in infraumbilical region 1x2cm size and artery could be passed through it of 5-6 cm length.Minimal small multiple serous discharge present on pfannenstiel incision.

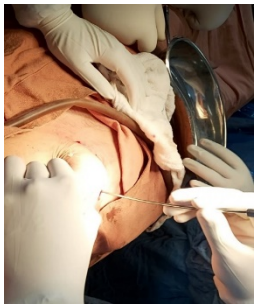

Fig 2. Probing withuterinesound to check the extent & length of fistulas tract

Investigations

- **Blood investigation:** TSH slightly elevated other parameters were WNL
- **Mantoux test:** negative
- **Pus culture sensitivity:** No growth after 48hrs of aerobic incubation
- **USG Abdomen & Pelvis:** Large continuous sinus tract with thin wall seen extending from Infraumbilical region to the anterior myometrium ~ 80mm in length with abscess 25 x 14 mm
- **MRI scan of abdomen and pelvis:** Fistulous abscess tract with internal and external opening

Management

Under SA exploratory laparotomy with complete excision of fistulous tract. Intraopertaive findings being Methylene blue

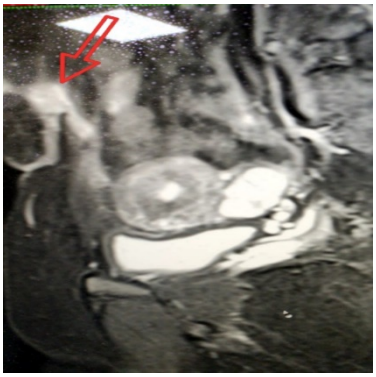

Fig 3. MRI showing fistulous tract with internal and external opening

is injected into the fistulous opening, the probing done & fistulous tract reached upto lower segment of uterine scar, excision of the tract done, The uterus and ovaries were normal. Specimen sent for HPE.

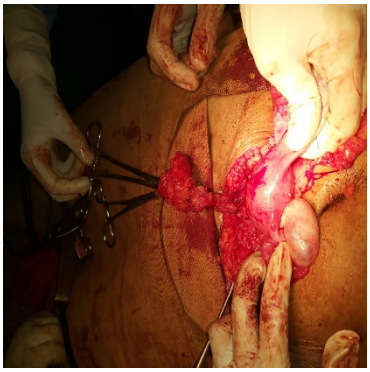

Fig 4. On table showing Cutaneous fistula extending to LSCS scar site

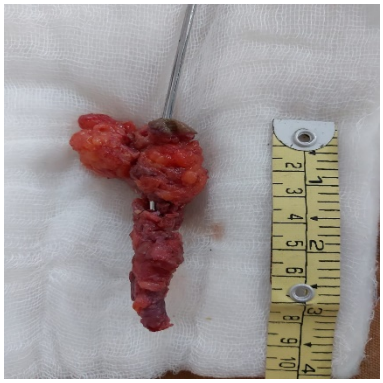

Fig 5. Fistulous tract complete excision measuring 9cm length

Histopathology

Features suggestive of chronic inflammatory lesion (sinus tract)

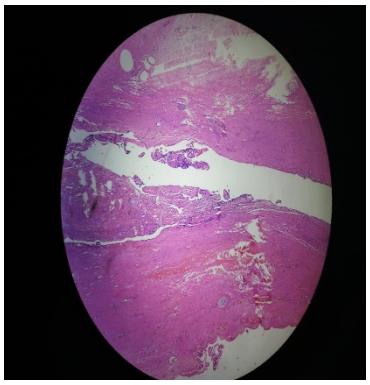

Fig 6. HPE showing chronic inflammartoy tract

Discussion

Uterocutaneous fistula is a very rare condition, there are a large number of causes for the formation of uterocutaneous fistulae such as lower-segment type of Cesarean section, abdominal pregnancy, and high delivery, whose pathophysiology is not fully understood but whose causes include multiple surgeries in the abdomen, use of drains, and in complete closure of incisions [(2)]. Previously, authors maintained that there was no nonsurgical treatment [(1)] and the range of the surgeries varied from the excision of the fistula tract [(1)] to hysterectomy [(1–5)], which presents a challenge in young patients. More recent reports, however , have introduced combined surgical and medical treatment for the reduction in the risk of hysterectomy [(2)]. Seyhan et al. reported a patient treated with gonadotropin-releasing hormone agonist (GnRH) alone: the GnRH agonist induces atrophic changes in the epithelium and assists in the closure of the fistula. Nonetheless, a larger size of fistula opening in patients prompt surgeons to opt for the surgical approach. Thubert et al. [(2)] used medical treatment and minimally invasive surgery (laparoscopy) for the excision of a fistula tract. We injected methylene blue through the external opening of the patient's skin to find the tracts and excise the fistula. over all only 26 cases reported in the past 50yrs. It is usually misdiagnosed as wound infection or an abscess. The approach to management is not clearly defined for the diagnosis of this condition . A Fistulogram, usg, mri or contrast-enhanced computed tomography (cect) may be helpful.

Conclusion

Despite the uncommon presentation of a Uterocutaneous fistula, it should be considered after Ceserean section - injury during operation, and abortion. Any women presenting with bleeding or discharge from the surgical scar post ceasrean section should always raise suspicion of u/c fistula formation.All surgeons should follow up patients with signs of inflammation. Fistulae need proper investigation and timely medical and surgical management such as antibiotics and Excision.

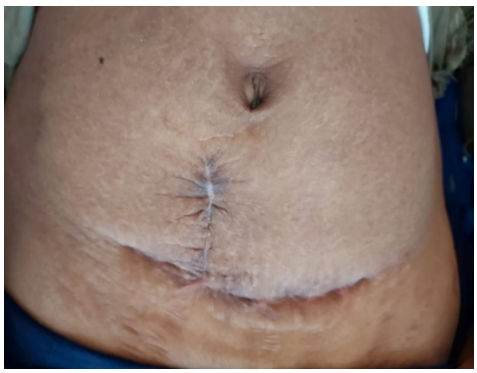

Fig 7. On follow after 3-months

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