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Case Report

Uterocutaneous Fistula : A Rare Clinical Presentation

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Abstract

A uterocutaneous fistula is a rare clinical presentation that occurs following Cesarean section and other pelvic operations. We report a case of Uterocutaneous fistula which was formed following lower segment caesarean section. USG was helpful in the diagnosis and was treated successfully with fistulectomy and repair of uterine wall. The case highlights the rare complication in caesarean section and diagnosis with USG and experience with its management.

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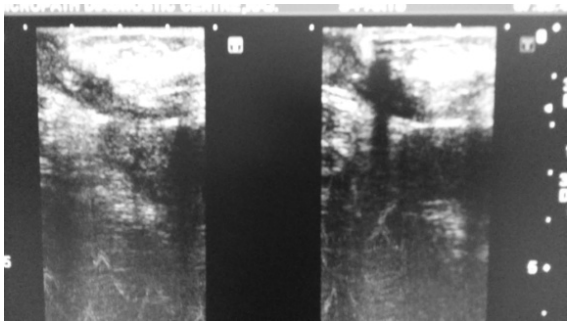
Introduction

A fistula is an abnormal communication between two epithelial surfaces. Fistulas are usually lined by granulation tissue but may be epithelialized. Gynaecologists are usually familiar with fistulas involving the urinary tract and the genital tract [1]. But uterocutaneous fistula is a rare entity mostly seen after post-partum or postoperative complications [2]. About 120 cases of uterocutaneous fistula have been reported in the world literature in its entirety over the past 200 years [3]. Other causes such as migration of laminaria tent and intrauterine contraceptive devices have also been reported [4,5] . There was a decrease of this type of complication corresponding with a decrease in the number of classical caesarean sections performed [6]. Herein we present a case of uterocutaneous fistula developed secondarily to caesarean section treated successfully with surgical management.

Case report

A 26 year old female Para – 2 came with complaints of pain on left lateral edge of pfannensteil scar and discharge through abdominal wall since 6 months. There is no history of fever or cyclical pain. Her menstrual cycles were 5/28-30 days with moderate flow and were almost regular since menarche. She underwent two Lower segment caesarean sections, 2nd caesarean was done 2 years prior to presentation. Her general physical examination was unremarkable and vitals were stable. On abdominal examination there was a low transverse scar in suprapubic region and a sinus in scar mark. Patient had periodical bleeding through sinus and at same time per vagina.



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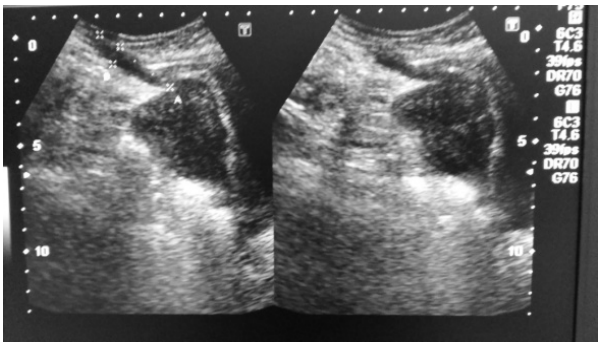

Fig – 01 : USG shows uterocutaneous fistula.

USG showed a sinus tract extending from endometrial cavity through myometrial wall into intramuscular planes from there to subcutaneous planes and skin. Fistulectomy was done and histological features were suggestive of endometrial tuberculosis with endometriosis.

Discussion

Uterocutaneous fistula usually results from post-partum or postoperative complications. Most fistulae originate from trauma or some other type of inflammatory processes that disrupt the continuity of tissues involved. The decrease in the incidence of uteroabdominal fistula may reasonably be attributed to marked decrease in the frequency classical caesarean type of operation in modern obstetrics [6,7]. Jain et al. reported uterocutaneous fistula following lower segment caesarean section [8]. Gupta et al. reported uterocutaneous fistula which developed following septic abortion induced by laminaria tent insertion in the cervix[5]. Literature review also showed possible etiologies: history of multiple abdominal surgeries, use of drains, incomplete closure of uterine wound following caesarean, intra-abdominal sepsis in previous scar, secondary abdominal pregnancy.

Promosonthi et al [9] in 2007 described a case of uterocutaneous fistula secondary to an abscess caused by in situ left placenta after an abdominal pregnancy. Eldemet al [10] in 2008 reported a case of uterocutaneous fistula developed secondary to CS performed 19 years ago. Baggishet al [11] in 2010 reported another case of uterocutaneous fistula as a complication of ruptured appendix and Crohn's disease during pregnancy. Pant et al [12] reported in 2012 a case of uterocutaneousfistula of tubercular etiology following CS. Uterocutaneous fistula is a rare condition that may be difficult to manage. Surgical excision of the fistulous tract is the treatment of choice.

Conclusion

Despite the uncommon presentation of a uterocutaneous fistula, it should be considered after Cesarean section, injury during operation and abortion. Once a fistula is diagnosed the basic principle in treatment is obliteration of opening of fistulous tract by surgical method. Early diagnosis and management can reduce the sufferings of a patient. The diagnosis of uterocutaneous fistula is based on clinical symptoms and radiological evidence of communication between uterus and skin by USG, CT, fistulography or MRI. USG is an ideal, easily available, low cost method for diagnosis of uterocutaneous fistula. If confusion arises then fistulography, CT-Scan or MRI can be done.

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