



مدينة الملك سعود الطبية
KING SAUD MEDICAL CITY

UTERO-CUTANEOUS FISTULA FOLLOWING CESAREAN SECTION: A CASE REPORT.

Dr. Noura Aldaham¹, Dr. Iman Yacoubi²

¹Consultant, Department of Obstetrics & Gynecology, King Saud Medical City, Riyadh, KSA.

²Associate Consultant, Department of Obstetrics & Gynecology, King Saud Medical City, Riyadh, KSA.

INTRODUCTION

Fistula is defined as an abnormal tract that communicates between two epithelial surfaces; Utero-cutaneous fistula is an extremely rare clinical entity and occurs due to the presence of an abnormal tract that communicates between the uterine cavity and the skin. This kind of fistula mostly occurs following uterine surgeries especially cesarean section and has other various etiologies including iatrogenic injuries during surgery, endometriosis, intrauterine devices, inflammatory processes related to intra-abdominal sepsis or infections, malignancies with local invasion to the adjacent organs, prolonged use of abdominal drains, radiation injury, trauma, and the incomplete closure of wounds particularly the uterine wall.

CONTACTS

¹dr_aldaham@live.com

²dr.eman25@hotmail.com

CASE REPORT

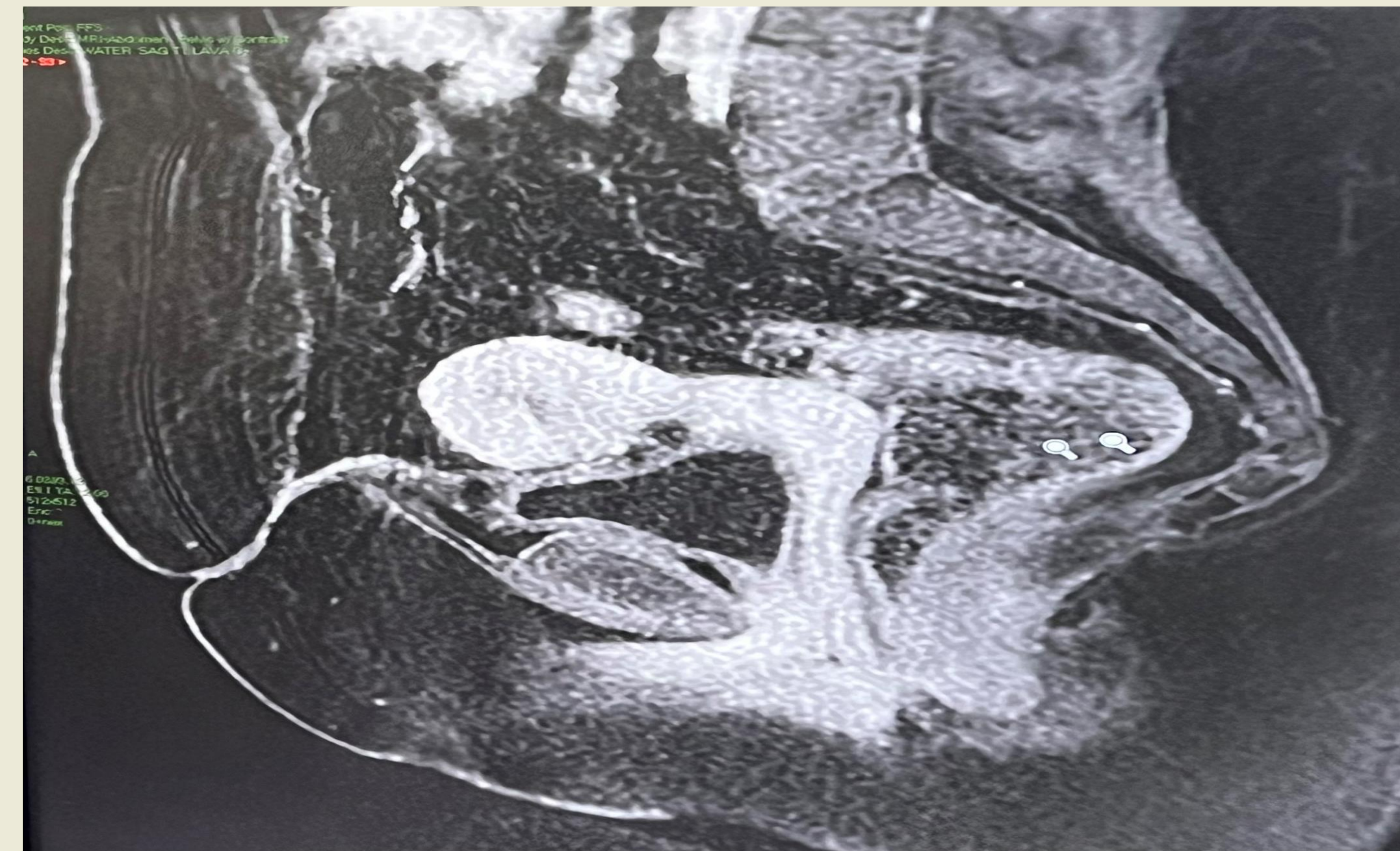
A 32 year old of BMI (body mass index) 45, diabetic on insulin and 4 previous cesarean sections was referred to the Obstetrics and Gynecology department four months after her last cesarean complaining of cyclical pain and blood discharge from the previous transverse supra pubic incision . Upon examination, no opening was seen. We performed MRI (magnetic resonance imaging), which showed a fistula tract between the uterus and skin. In the operation – with guidance of a small metallic catheter, methylene blue was injected to identify the tract, then complete excision of the tract was done which measured 8cm. Removal of necrotic tissue and refreshment of the edges was performed .Then the uterus was re-sutured with omental flap fixed. The patient’s follow up was done for 6 months with no post-operative complications and regular menstrual cycle with no recurrence.

DISCUSSION

The classical presentation is that the patient is present with cyclical bleeding from an abnormal opening in the scar of a previous cesarean section. The management of utero-cutaneous fistula is stepwise and involves careful assessment of the patient’s general condition with investigations to detect the underlying cause. Multiple imaging techniques confirming the diagnosis had been reported. Fistulography with the injection of the contrast material through the cutaneous fistulous opening confirms the connection to the uterus. Hysterosalpingography with a methylene blue injection through the cervix is used when the cutaneous opening is too small. CT scan with intravenous injection of contrast medium and MRI can also identify the fistula.

Figure 1.

MRI showing a continuous tract opening from the previous anterior uterine wall to the subcutaneous tissue



SURGICAL INTERVENTION

In the Theatre, the Patient directed us to the site of blood discharges during menstruation, the site was then marked.

Under general anesthesia and all aseptic precaution, a small metallic catheter was inserted through the marked site to identify the tract then methylene blue was injected. The whole previous scar incision was opened, anterior wall was opened layer by layer, omental adhesion was found , and adhenolysis was done. Abnormal Fistulous tract was identified which connects the previous scar incision to the uterus and endometrial cavity, it measured about 8 cm. Complete excision of the tract was done, there was a uterine defect which measured about 1.5 cm, removal of necrotic tissue and refreshment of the edges was performed . Then the uterus was re-sutured, omental flap fixed, anterior wall closed, bladder inflated with methylene blue intact, and then the abdominal wall was closed
Surgery ended without complications.

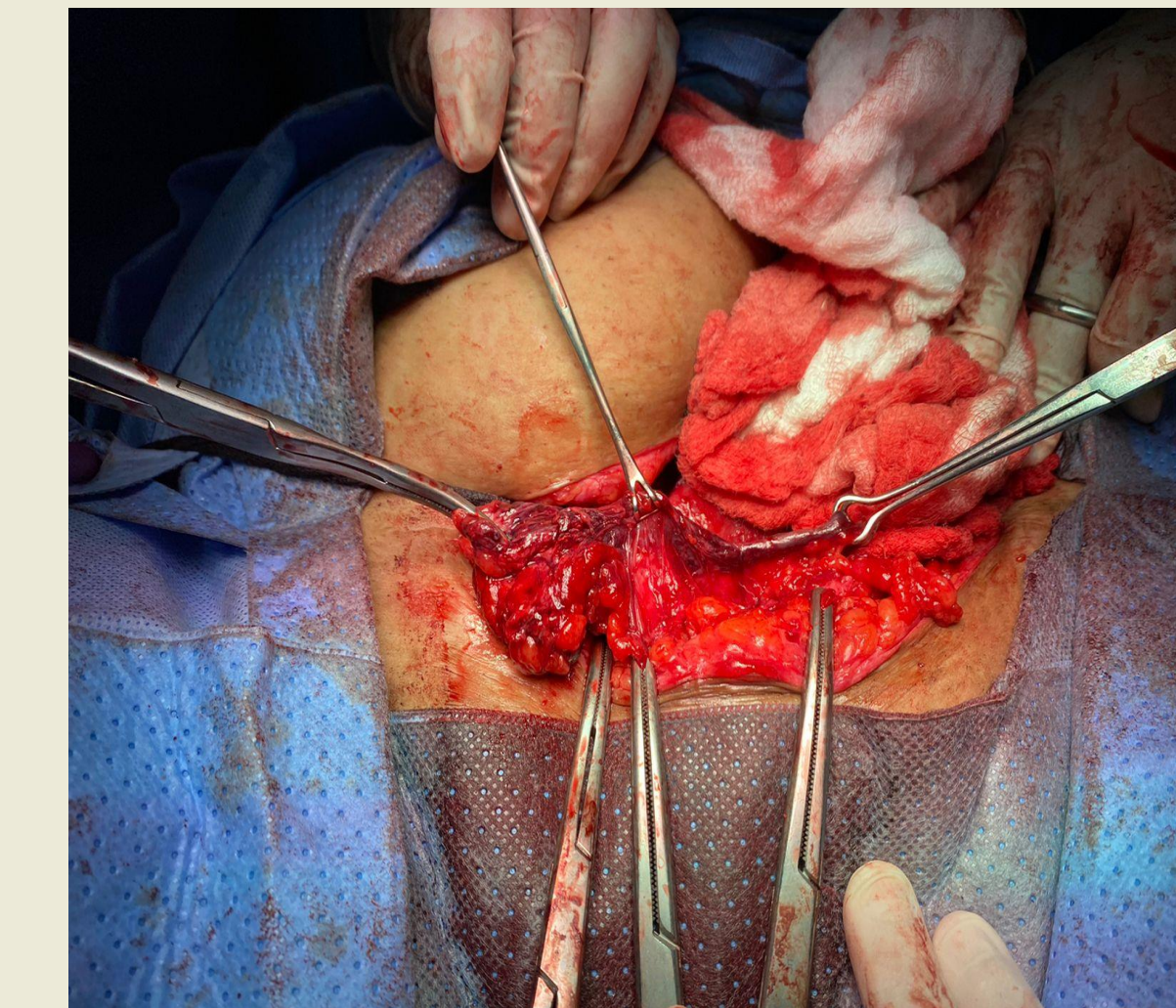


Figure 2. and 3.

An intra-operative picture showing the fistulous tract between the skin and the uterus

FOLLOW-UP AND OUTCOMES

The patient’s follow up was done for six months regularly with no post-operative complications and normal regular menstrual cycles. Per abdomen she had a healthy clean intact scar with no gap and no discharge. Her utero-cutaneous fistula tract showed endometrial glands and stroma and her post-op MRI showed no fistula tract.

CONCLUSIONS

Although utero-cutaneous fistula is rare in cesarean sections, more attention should be paid to the quality of suturing as well as wound management after surgery, due to prolonged wound healing in diabetic patients. The best surgical management involves excision of the whole fistulous tract, and follow up is recommended for early detection of any post-operative event.