

RETAINED PRODUCTS OF CONCEPTION IN A UTERO CUTANEOUS FISTULA: A CASE REPORT

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ABSTRACT

This is a case report of a patient with utero-cutaneous fistula following Caesarean Section and criminal abortion. Her case was further complicated by the discovery of products of conception within the fistula. At laparotomy, adhesiolysis with the freeing of the uterus and fistulectomy were performed. She had an uneventful recovery.

Key words: Cesarean Section, Criminal Abortion, Utero-Cutaneous Fistula

(Accepted 20 July 2007)

INTRODUCTION

Utero-cutaneous fistula occurs when there is an abnormal connection between the endometrial cavity and the skin. It is a very rare complication of Caesarean sections. Dragoumis et al (2004) ¹ claimed that theirs was the second case to be recorded in the literature and the first to be associated with endometriosis. Rarer still is utero-cutaneous fistula with retained products of conception as discussed by us. We did not find a similar case in the medical literature. In this case, the presence of dense adhesions which resulted in the uterine fundus being bound to the anterior abdominal wall and the discovery of fetal bones in the fistula suggest both post Caesarean section sepsis and complications of subsequent termination of an unwanted pregnancy as aetiological factors. The few cases of utero-cutaneous fistula found in the literature were managed by performance of total abdominal hysterectomy. The index patient was very young, had no living child and our approach was therefore conservative.

CASE REPORT

A 21 year old student presented in March 2002, with a 6 month history of intermittent pain and persistent discharge of pus from a wound just below the umbilicus. The same wound also bled during menstruation. Her last menstrual period was on 20/2/02. Duration of flow was 4 days with a regular cycle of 28-30 days. Blood loss was average with mild dysmenorrhea.

She had an emergency Caesarean section two years prior to presentation, which resulted in delivery of a fresh stillbirth. The indication was fetal distress after prolonged labour. Post operative infection set in with delayed her eventual discharge from hospital by 14 days.

A year later she had a termination of an unwanted pregnancy at about 14-16 weeks gestation.

General examination was essentially normal. Abdominal examination revealed a broad and thick sub umbilical midline scar with a discharging sinus just below the umbilicus.

On pelvic examination, the vagina was normal. The cervix was unusually high up and was exposed with difficulty. It however appeared grossly normal. The uterus was bulky with restricted mobility. There were no adnexal masses. Swabs were taken from the discharging wound, cultured and appropriate antibiotics prescribed. Failure of the wound to heal led to its exploration under local anaesthesia about two weeks later. Several fetal bones including the femur and scapula were extracted. An abdomino-pelvic ultrasound scan was ordered for and preparations made for laparotomy. The scan report was as follows: "a normal sized anteverted uterus with an upper segment echogenic anterior wall track connecting from the endometrium to the serosa. Ovaries ----- no abnormality detected". Haemoglobin estimation was 7.5g/dl. Two units of blood were cross matched.

Exploratory laparotomy was performed on 5/4/02. Dense intra abdominal adhesions were noted. The uterus was bulky and had been pulled up to the level of the umbilicus and the fundus was adherent to the anterior abdominal wall. It was literally "plastered" onto the anterior abdominal wall. The tubes and ovaries appeared normal. Adhesiolysis with freeing of the uterus and fistulectomy were performed. The uterine wound was repaired with chromic 1 catgut. Post operative recovery was uneventful.

DISCUSSION

Fistulae involving the uterus are very rare usually

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being the result of postpartum and post operative complications¹. Other causes include endometriosis and tuberculosis^{1,2}. In this case, the history of post Caesarean infection and the presence of dense intra abdominal adhesions at laparotomy suggest infection as an aetiological factor. Subsequent termination of pregnancy could also have produced additional sepsis.

In the few cases in the literature and the index case, Caesarean section was a common feature. It would appear that post Caesarean sepsis provided the crucial step in the formation of the fistula, which was the adherence of the uterus to the anterior abdominal wall. Thus, the distance between the endometrial cavity and the skin was thereby bridged.

The interval between the preceding Caesarean section and the appearance of the fistula was variable. Dragoumis' case¹ presented 6 years after her 4th Caesarean section. Veena's patient³ presented 3 months after her 3rd Caesarean section whilst ours presented two years after her only Caesarean section.

The next puzzle was the presence of fetal bones in the anterior abdominal wall. The uterus was probably perforated during the termination of pregnancy. Since the uterine fundus was already anchored to the anterior abdominal wall, the perforating instrument therefore pierced the uterus and entered the anterior abdominal wall.

We surmise that the unwanted pregnancy was not completely evacuated during the attempted abortion.

The remaining products of conception might have become lodged within the anterior abdominal wall during the crude evacuation process as the termination was performed by an unqualified practitioner.

Three cases of utero-cutaneous fistula found in the literature were treated by total abdominal hysterectomy^{2,3}. Our approach was however conservative, due to the young age of the patient and the need to preserve her reproductive capability. This case highlights an unusual presentation of a rare clinical entity and complication of Caesarean section and crude termination of pregnancy.

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