CASE REPORT

COLOUTERINE FISTULA WITH A FOREIGN BODY

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Foreign bodies in vagina are known to have been inserted by the patient herself or by some other person; as an aid to masturbation, sexual intercourse or sexual assault. The two most common items retained in adult females are tampons and burst condoms. Since long, vaginal deliveries and Obstetric and Gynaecological interventions have been associated with vesicovaginal and rectovaginal fistulae. We present a case of a 24 years old Pakistani woman with a colouterine fistula. Although vesicouterine fistulae have rarely been reported previously, world-literature has only a few documented cases of colouterine fistula.

Keywords: Colouterine fistula, fistula, primary repair

INTRODUCTION

This case report does not only present a rare fistula, that is, colouterine fistula, but also signifies the complications associated with treatment by untrained health workers. Colouterine fistulae can be deleterious for an infertile female because of introduction of infection via the colon. Treatment of colouterine fistula in parous women is hysterectomy followed by repair of rent in the colon. We present for the first time the case of a colouterine fistula in which repair of both the rents was done as a primary procedure. The uterus was conserved because the patient was a nulliparous woman.

CASE REPORT

A 24-year-old Pakistani housewife resident of Mianwali, Punjab, educated up to grade 5, married for last 7 years was referred from PAF Hospital Mianwali with complaints of passage of blood in stools during menstruation for last 3 years. Patient was a case of primary infertility. She had a menstrual cycle of 3/90 days since menarche. She went to a Lady Health Visitor in Mianwali about 4 years back who examined her and advised her Dilatation and Curettage. Patient agreed to the procedure and the procedure was done in a private clinic without any anaesthesia/analgesia. Following her D&C her menstrual cycle remained the same with the addition of pain in left iliac fossa and Dyspareunia. She also developed purulent foul smelling vaginal discharge. A year later she noticed passage of blood in stools during menstruation. There was no history of bleeding from any other site or dysmenorrhoea. There was no history of passage of faecal matter through vagina. Ultimately the Lady Health Visitor sent her to a Gynaecologist in Mianwali who referred her to Military Hospital Rawalpindi. On examination, she was a young lady, conscious and oriented, with normal vital signs, and no significant finding on systemic examination. Local examination revealed normal vulva, vagina and cervix. Digital pelvic examination revealed a normal sized anteverted uterus with no mass or tenderness in the fornices. Ultrasound pelvis was normal. Her Hystero-Salpingogram was done. The HSG revealed patent right fallopian tube (Figure-1). The dye instead of the left fallopian tube outlined the large gut and the same evening patient passed the dye in her stools (Figure-2). A provisional diagnosis of Uterocolic fistula was made and patient was prepared for Laparotomy. The procedure was explained to the patient and a written informed consent was obtained. All her pre-op investigations were within the normal limits. Patient was put on Injection Metronidazole 500 mg 8 hourly and put on liquid diet 24 hours before the surgery. Abdomen was opened by midline incision. Left side of the uterus was encased in dense adhesions with sigmoid colon and omentum (Figure-3). Adhesiolysis was done and the site of the uterocolic fistula was dissected (Figure-4). When the uterus was separated from the colon a foreign body was found bridging the site of fistula (Figure-5). This foreign body was almost the size and shape but a little larger than a wooden tooth-pick (Figure-6). The field was not soiled with faecal matter. Vicryl 3/0 was used to repair the gut in two layers (Figure-7). The rent in the gut was almost 3 mm in diameter. Uterine rent was also stitched (Figure-8). Stitches in the colon were sealed by pericoloic fat. Peritoneal lavage was done and drain was placed in pelvic cavity (Figure-9). Abdomen was closed in layers. Anal dilatation was done and patient was put on broad spectrum antibiotics. Patient was kept NPO for next 5 days and given parenteral nutrition. Patient passed stools on 1st and then on 6th post operative day. The drain was removed on 9th post operative day and the recovery was uneventful.

DISCUSSION

Foreign bodies in vagina are known to have been inserted as an aid to masturbation, sexual intercourse or sexual assault. Incidence of foreign bodies in pelvis is more common in reproductive age. These may be inserted by the patient herself or by other person. Patient may present early with history of foreign body insertion into vagina or many a times they hesitate in telling the history until and unless some complications arise like traumatic injuries to vagina, rectum, urethra or bladder.[1] In adult women the two most common items are retained tampons and burst condoms.

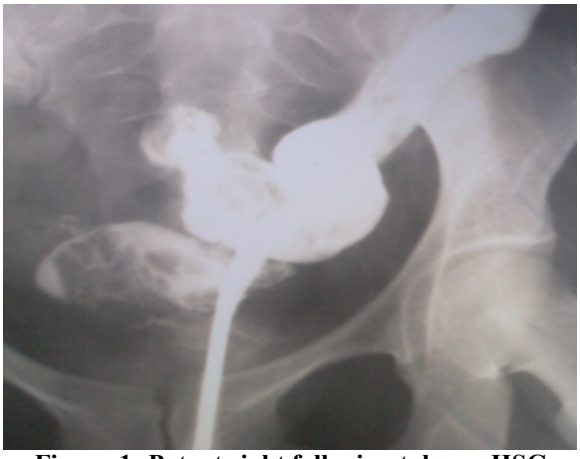

Figure-1: Patent right fallopian tube on HSG

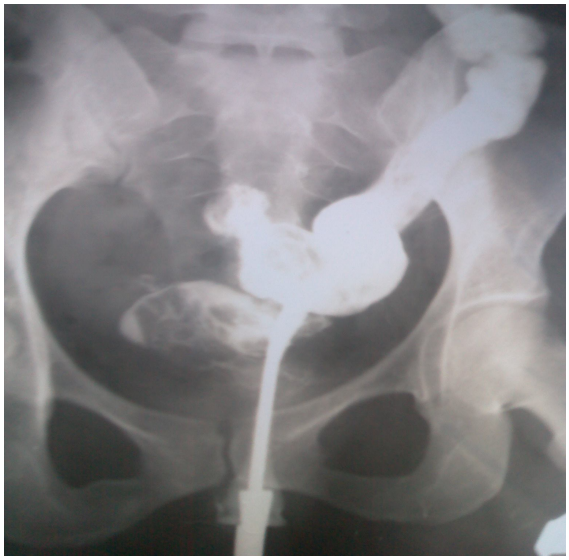

Figure-2: Outlined gut on HSG

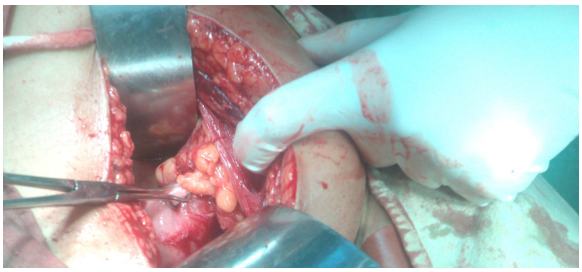

Figure-3: Colo-uterine fistula

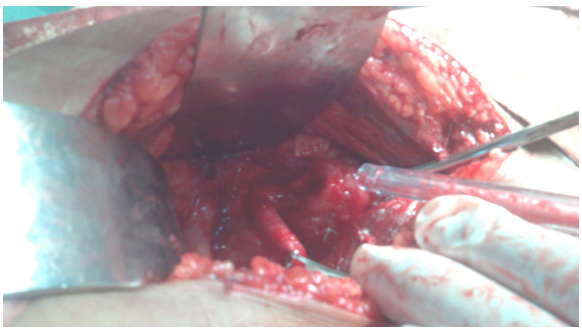

Figure-4: Fistulous site dissected

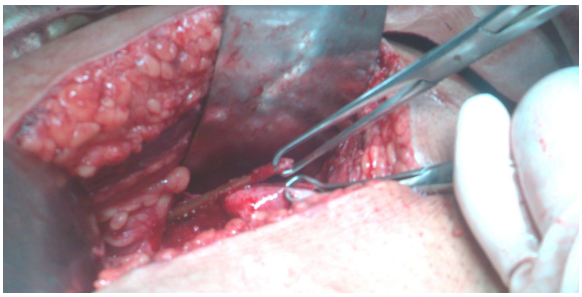

Figure-5: Stick bridging the uterus and intestine

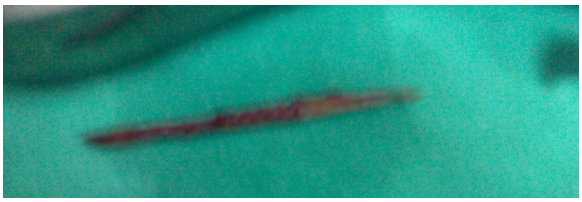

Figure-6: Removed stick

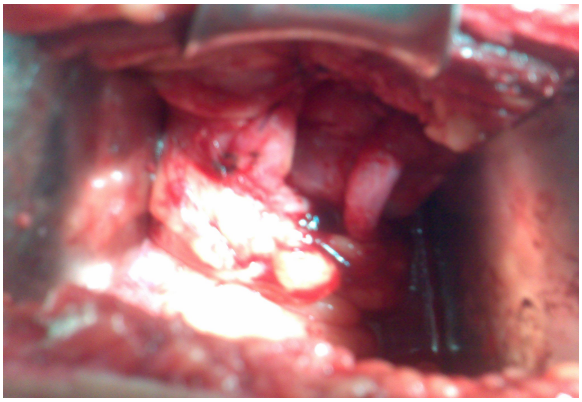

Figure-7: Rent in the intestines covered with pericolic fat

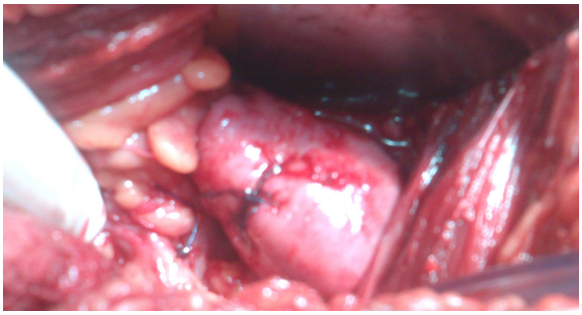

Figure-8: Rent in the uterus closed

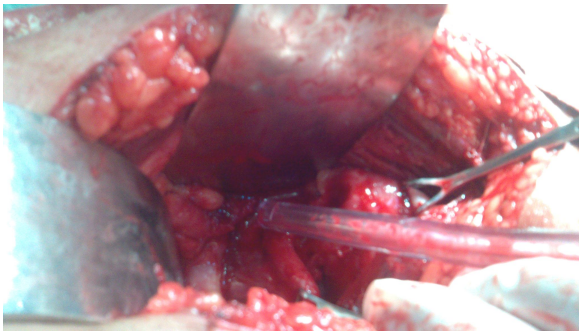

Figure-9: View before closure

Since long vaginal deliveries and Obstetric and Gynaecological interventions have been associated with vesicovaginal[2], and rectovaginal fistulae[3]. Vesicouterine fistulae[4] are relatively rare but world literature documents only few cases of colouterine fistulae.[5] Usually these cases of colouterine fistulae were diagnosed by Computerised Tomography[6] or Sonohysterography[7] but in our patient just the conventional Hysterosalpingography lead to the diagnosis. Usually colouterine fistulae documented till now were secondary to malignancy[8], diverticulitis[8] and endometeriosis. All these cases were treated by hysterectomy and resection of sigmoid colon[9] or colostomy with subsequent repair[10]. We report this case of colouterine fistula with successful primary repair without hysterectomy for the first time.

Initial evaluation comprises a detailed history. Important information includes associated symptoms, such as pain, fever, or changes in bowel or bladder function. Intrauterine foreign bodies are usually rare, apart from intrauterine devices.

A high index of suspicion is required for diagnosis of foreign bodies in the pelvis. One does not expect any contraceptive device or foreign body in an infertile patient. The Foreign bodies introduced in the pelvis by dais and Traditional Birth Attendants not only creates fistulae but can also worsen the fertility prognosis in a patient. Education and awareness of general population is important to encourage patients to report to concerned specialist rather than Lady Health Visitors.

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