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A rare case of recto - uterine fistula following LSCS

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Abstract

Introduction: Recto-uterine fistula is a very rare condition, which includes a communication between the epithelial surfaces of the rectum and uterine cavity causing various symptoms like fecal incontinence, fecoloid leucorrhoea etc.

Case report: A 22 year old para2 lady presented to us with a recto-uterine fistula following a cesarean section. Excision of the fistula, primary bowel defect repair and hysterectomy was done for her following which she had an uneventful recovery.

Conclusion: Recto-uterine fistula in a young woman with no co morbidities following a cesarean section even though extremely rare is a significantly distressing condition and a very possible complication to be feared. And hence this case is being reported for general information and pertinent discussion.

Keywords: Recto-uterine fistula, fecal incontinence, posts cesarean section

Introduction

Colo-uterine fistula is a very rare condition; most cases described in the literature occurred secondary to complications of diverticulitis in the elderly [1,2]. Other circumstances include sigmoid malignancy [3], radiotherapy and iatrogenic conditions such as insertion of intrauterine devices [4], endometrial curettage with uterine and bowel perforation [5], or obstetrical injury [6].

Case report

A 22 year old woman, Para 2 presented with complaints of fecal incontinence and passage of feces per vagina from past five weeks. She gives history of full term emergency LSCS six weeks back. Indication for the same was previous LSCS with patient in labor and an unfavorable cervix. She delivered a healthy baby weighing 2.75kg. No per operative complications were mentioned in the operative notes. Immediate post operative hospital stay was uneventful and patient was discharged on day 5. She developed her aforementioned symptoms about 3 days following discharge. She gives no history of similar complaints or any history of bowel disturbances suggestive of inflammatory bowel disease or any surgeries in the past.

On examination: General condition of the patient was fair. Vitals stable. Per abdomen: no abnormalities detected. LSCS scar was well healed. Local examination revealed no positive findings. On speculum examination, fecal matter coming through the os was noted (Fig.1). Per vaginal examination

revealed a normal sized uterus, mobile with no adenexal masses. Per rectal and recto vaginal examinations showed no evidence of rectovaginal fistula. Barium enema was done which delineated a small fistulous tract between the upper part of the rectum and posterior wall of uterus.

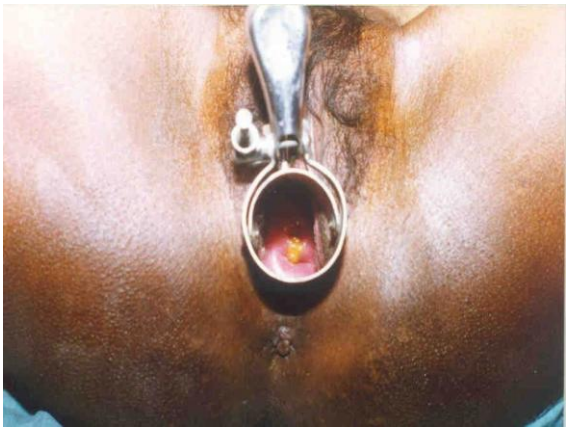

Fig. 1: Speculam examination demonstrating fecal matter coming through the cervical os.

Intravenous antibiotics were started immediately and she was counseled about the need for hysterectomy. Laparotomy enabled us to isolate the fistula between her rectum and the posterior surface of her uterus, with feces inside her uterus, but with no signs of fecal peritonitis. We then proceeded with excision of the fistula. The defect over the rectum was repaired in two layers and hysterectomy was done since the patient had completed her family. Histopathological analysis of the specimen was benign. The postoperative recovery of the patient was timely; she regained her bowel functions on day 3 and was discharged on day 5. On her follow up examination at 6 weeks, no abnormalities were detected.

Discussion

Historically colo-uterine fistulae are most commonly either seen in the frail and the elderly associated with diverticulitis or malignancy, or in the young with inflammatory bowel disease. Iatrogenic fistulae following myomectomy especially after UAE[7] or following insertion of an intra-uterine device have been reported. Treatment in these cases included antibiotics followed by a hysterectomy and bowel resection anastomosis or rarely a conservative fertility sparing surgery which did not include a hysterectomy.

To the best of our knowledge this is the first case of a recto-uterine fistula following a cesarean section to have been reported. Our postulation for the cause includes an extension of the uterine incision during LSCS during the repair of which there might have been an inadvertent bite taken through the rectum leading to necrosis of that part of the rectum and an eventual fistula formation.

Conclusion

Recto-uterine fistula in a young woman with no co-morbidities following a cesarean section even though extremely rare is a significantly distressing condition and a very possible complication to be feared. The diagnosis can be made by classical history of fecoloid leukorrheoa, supported further by examination to demonstrate the same and some form of an imaging modality (barium enema in his case) to confirm it. The treatment should address 3 prime aspects – sepsis prevention by broad spectrum antibiotics, correction of the defect – excision of the fistula and bowel injury repair and elimination of the septic focus – hysterectomy. Conservative surgical management is challenging in case of severe infection, but should be discussed if fertility preservation is strongly desired.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images.

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