Uterocutaneous fistula

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Summary: **Fistulous communications of the uterus are relatively unknown. We report in this paper the first case to our knowledge of uterocutaneous fistula which developed following a septic abortion induced by introduction of Laminaria tent into the uterus.**

Introduction

Surgeons and gynaecologists are familiar with vesicovaginal, ureterovaginal and rectovaginal fistulae. These result from injuries sustained during childbirth and various surgical procedures or may be radiation induced. Some of them are associated with chronic granulomatous infections like tuberculosis and Crohn's disease¹ while others may be due to tumour infiltration. Fistulous communications of fallopian tube with perineum² and with appendix³ have been reported but uterocutaneous fistula is a rarity. The authors have not come across any reported case of uterocutaneous fistula in the medical literature and believe this to be the first such case.

Case report

A 32-year-old female gravida 4 para 3 presented with a persistent discharging sinus in the right flank for 10 months. This was preceded by a septic abortion carried out 2 months earlier using a Laminaria tent elsewhere. Fifteen days after the abortion she developed pain and swelling in the right perinephric area with high-grade pyrexia, chills and rigors. Incision and drainage was carried out and nearly 400 ml of frank pus was drained. The patient improved but 10 days later developed similar features of pain and pyrexia with a swelling in the right flank which was acutely inflamed and tender. Incision and drainage was done again and about 200 ml of pus came out. The wound failed to heal and she had serous discharge from the site. A few days later at the normal time of her menstruation the patient noticed that she had no menses per

vaginum but the entire menstrual flow drained through the unhealed wound. She underwent two operations at another hospital at intervals of one month each for the excision of the fistulous tract, both of which failed and she continued to have her menstrual outflow through the fistulous opening.

General examination of the patient was unremarkable except that she was slightly pale. A solitary fistulous opening about 2–3 mm in diameter was present in the right flank about an inch below the superior border of the right iliac crest over a healthy scar of 10 cm length. Sprouting granulation tissue was present at the opening. A vague lump extending into the pelvis was felt in the right iliac fossa, which was non-tender and non-mobile. Vaginal examination revealed a fibrotic stenosis of the cervical os through which a uterine sound could not be negotiated. The right fornix was fibrosed and thickened. Fistulogram revealed the free passage of the contrast material into the uterus which failed to pass into the cervix (Figure 1).

Figure 1 Fistulogram showing passage of contrast material to the uterus.

Exploratory laparotomy revealed the fistula opening internally at the isthmus of the uterus. At the isthmus the uterus was perforated and fetal remnants in the form of a few long bones were lying outside. A loop of the small bowel was densely adherent at this site which perforated during separation. There was no evidence of regional ileitis or endometriosis. Abdominal hysterectomy and resection and anastomosis of the small bowel was carried out. (The couple had requested sterilization.) The fistulous tract was excised. Histopathology revealed no evidence of endometriosis, Crohn's disease or tuberculosis. Postoperative recovery was uneventful and the external opening healed completely.

Discussion

A fistula is an abnormal communication between two epithelial surfaces. Fistulae are usually lined by

granulation tissue but they can become epithelialized. Most fistulae originate from trauma or from some type of infectious process that disrupts the continuity of the tissues involved. Once a fistula is diagnosed the basic principle in the treatment is obliteration of the primary opening of fistulous tract. There is no non-surgical treatment for fistula.⁴

In this case the patient possibly developed uterine perforation leading to pelvic abscess extending to perinephric and right flank region due to septic abortion which were drained subsequently. Conceivably the uterine perforation with stenosis of the cervix due to interference led to communication with the right flank and drainage through this area gave rise to the uterocutaneous fistula. Injection of contrast through the fistulous opening permitted an accurate diagnosis and extirpation of the uterus produced a cure.

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Type IV renal tubular acidosis associated with Alport's syndrome

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Summary: A case of hereditary nephritis with mild reduction of renal function associated with renal tubular acidosis type IV is described. The patient was admitted with life-threatening hyperkalaemia. To our knowledge, type IV renal tubular acidosis has not been reported previously in association with Alport's syndrome in an adult patient.

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Introduction

Hereditary nephritis or Alport's syndrome is a heterogeneous group of inherited abnormalities of