

An Unusual Case of Colon to Uterine Faecal Fistula Following Traumatic Uterine Perforation: A Case Report

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Abstract

Maternal mortality continues to be high in India particularly in the rural setups where awareness is less and proper obstetric and gynae facilities are not available (1). An unusual case of traumatic perforation of uterus and injury to sigmoid colon leading to colon- utero faecal fistula is presented. An early diagnosis by ultra sonography and management by timely obstetric hysterectomy and colostomy was done to save the life . This was followed by closure of colostomy after one month. The patient made an uneventful recovery.

Keywords: Genital Tract fistulae; Septic Abortion; Maternal Mortality; Faecal Fistula; Uterine Perforation; Traumatic Uterine Perforation.

Introduction

Unsafe abortion is major cause of maternal death. According to the World Health Organization, every eight minutes a woman dies from complications arising from unsafe abortions. Complications include hemorrhage, infection, sepsis and genital trauma (2). Globally, preventable deaths from improperly performed procedures constitute 13% of maternal mortality, and 25% or more in some countries where maternal mortality from other causes is relatively low, making unsafe abortion the leading single cause of maternal mortality worldwide (3) .

Case Report

This 26 year old lady gravida three para two with two normal deliveries in the past has been brought to Jodhpur medical collage and hospital , Jodhpur. She gave history of four and half months pregnancy when she had a fall from the stairs at home about 20 days back and started profuse bleeding per vagina. She was taken to local untrained practitioner where she has undergone abortion and instrumentation. Since then she has been having bleeding per vagina and pain in abdomen off and on. She has been now passing faecal matter per vaginum since last 8-10 days. . On examination weight 52 kg pulse 110 /mt BP 100/60 MMOF HG PALLOR ++ fever intermittent 102 °F. On per abdominal examination there was a palpable lump, in the hypogastric region of the abdomen. The lump is pear shaped 14-16 week uterine size soft non tender and mild free fluid in the abdomen. Moderate rigidity and guarding was present. Per speculum examination showed fecal matter coming out of cervical os. Per vaginal exam showed 14-16 week uterine size soft but fixed. Plain X Ray of the abdomen in standing position is indicative of gas under diaphragm and distended bowel loops. Central abdominal mass showed fetal bones with fetal head. Ultra sonography of the abdomen revealed perforated/ ruptured gravid uterus with incomplete fetal parts (macerated partial fetal bony structure indicating skull) lying outside the uterus within the abdomen approx gestation 18 weeks no evidence of fetal movements or fetal cardiac activity seen. Air within the endometrial cavity and cervical canal suggestive of endometritis and moderate Collection in the POD(fig 1,2). Broad spectrum antibiotics were given and two units of whole blood was transfused. Bowel cleansing agents were given and bowel was

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Fig.1



Fig.2

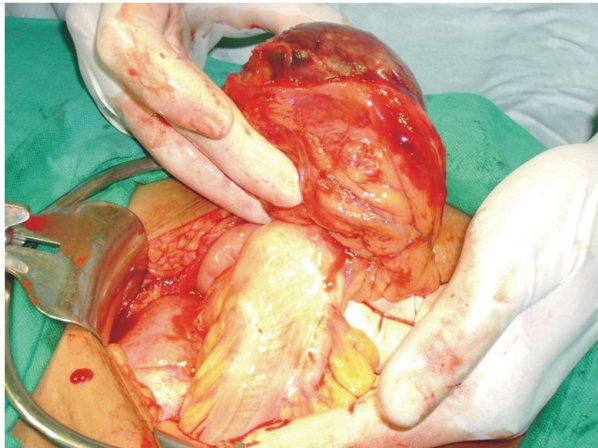


Fig.3

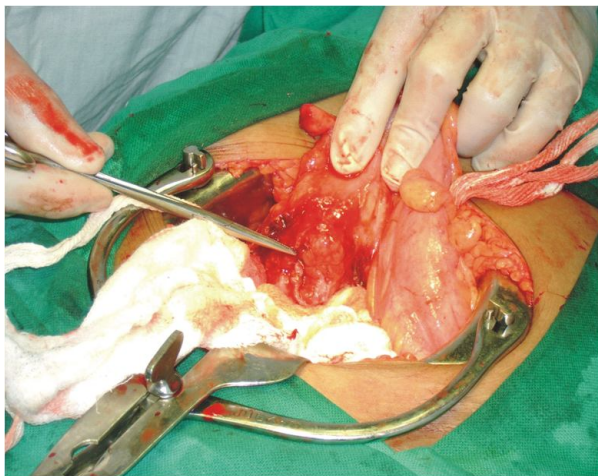


Fig.4



Fig. 5

properly prepared with bowel wash. Patient was taken up for exploratory laparotomy. Laparotomy showed macerated fetal skull and fetal parts lying outside uterine cavity with dense adhesions of omentum. The placenta was lying along with fetus outside uterine cavity. There was a big perforation of three inches by two inches in the posterior wall of

uterus. The recto sigmoid junction showed a big perforation of 2-3 inches with omental adhesions (fig 3,4). Fetal parts fecal matter and peritoneal fluid was cleaned up with drainage. Uterus was dissected clear of sigmoid colon and repair of perforation was done with 2/0 silk with traumatic needle. Uterus was in bad shape with irregular edges and hence an obstetric hysterectomy was performed. Transverse colostomy was performed (fig 5). Patient made a slow but progressive recovery and was discharged on twelfth post operative day. Closure of colostomy was done after six weeks. Follow up of patient after eight weeks has shown uneventful recovery.

Discussion

The World Health Organization (WHO) reported that India's MMR, which was 560 in 1990, reduced to 178 in 2010-2012. The decline in maternal deaths has been largely due to improved asepsis, fluid management and blood transfusion, and better prenatal care. (4)

However, as per the MDG Millennium Development Goal (MDG) mandate, India needs to reduce its MMR further down to 103. India accounts for the maximum number of maternal deaths in the world — 17 per cent or nearly 50,000 of the 2.89 lakh women who died as a result of complications due to pregnancy or childbearing in 2013. "Literacy and social issues are major factors that have led to high maternal deaths. Girls are married at a young age and they have little knowledge about early pregnancy. (5)

The WHO notes that in 2014 the major direct causes of maternal deaths globally are: severe bleeding/hemorrhage (27%), infections (11%), unsafe abortions (8%), high blood pressure during pregnancy (pre-eclampsia and eclampsia) (14%), obstructed labour (9%), blood clots/embolism (3%) and pre-existing conditions (28%).^[3] Indirect causes are malaria, anaemia, HIV/AIDS, and cardiovascular disease, all of which may complicate pregnancy or be aggravated by it.(6)

Socio demographic factors such as age, access to resources and income level are significant indicators of maternal outcomes. Young mothers face higher risks of complications and death during pregnancy than older mothers, especially adolescents aged 15 years or younger.^[6] Adolescents have higher risks for postpartum hemorrhage, puerperal endometritis, operative vaginal delivery, episiotomy, low birth weight, preterm delivery, and small-for-gestational-age infants, all of which can lead to maternal death.

Structural support and family support influences maternal outcomes. Furthermore, social disadvantage and social isolation adversely affects maternal health which can lead to increases in maternal death. (7) Additionally, lack of access to skilled medical care during childbirth, the travel distance to the nearest clinic to receive proper care, number of prior births, barriers to accessing prenatal medical care and poor infrastructure all increase maternal deaths. Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. Improving access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth will reduce maternal deaths significantly. It is particularly important that all births be attended by skilled health professionals, as timely management and treatment can make the difference between life and death. To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system. (8) Recommendations for reducing maternal mortality include access to health care, access to family planning services, and emergency obstetric care, funding and intrapartum care. (9) Reduction in unnecessary obstetric surgery has also been suggested. Family planning approaches include avoiding pregnancy at too young of an age or too old of an age and spacing births. Access to primary care for women even before they become pregnant is essential along with access to contraceptives. (10).

References

- Haddad, L. B., & Nour, N. M. (2009). Unsafe abortion: unnecessary maternal mortality. *Reviews in obstetrics and gynecology*, 2(2), 122.
- Khlat, M., & Ronsmans, C. (2009). Deaths Attributable to Childbearing in Matlab, Bangladesh: Indirect Causes of Maternal Mortality Questioned. *American Journal Of Epidemiology*, 151(3), 300-306
- Conde-Agudelo A, Belizan JM, Lammers C. Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. *American Journal of Obstetrics and Gynecology*, 2004. 192:342–349
- Bhutta, Z. A.; Black, R. E. (2013). "Global Maternal, Newborn, and Child Health — So Near and Yet So Far". *New England Journal of Medicine* 369 (23): 2226
- Costello, A; Azad K; Barnett S (2006). "An alternative study to reduce maternal mortality". *The Lancet* 368 (9546): 1477–1479
- WHO, UNICEF, UNFPA. Maternal mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA. Geneva: WHO, 2003.
- Pattinson RC, Hall M. Near misses: A useful adjunct to maternal death enquiries. In Rodeck C. *Pregnancy – Reducing maternal death and disability*. Oxford Univ Press, London 2003; (67):231- 243.
- Annual report of family health. Colombo, Sri Lanka: Evaluation unit, Family Health Bureau, Ministry of Health, 2000. National Health policy, Ministry of Health & Family Welfare. 1982.
- Govt. of India (2002), Annual Report 2001-2002, Ministry of Health & Family Welfare, New Delhi.
- Bedi N, Kamboj I, Dhillon BS, Saxena BN, Singh P. Maternal Deaths in India. Preventable tragedies (An ICMR Task Force Study). *J Obstet Gynaecol Ind* 2000; 51 : 86 – 92.