ABSTRACT

Utero-cutaneous fistula is a rare condition which is characterized by an abnormal communication between the anterior wall of the uterus and the abdominal wall. The causes are multiple caesarean sections, abortions, uterine cavity revision, retention of placental material after delivery, endometriosis, use of drains, post-operative infections, or injuries. Blood discharge from the caesarean scar during menstruation is a prominent feature as in our case. Here we present a case of para 2 living 1 lady, with previous 2 caesarean section presented to our Gynecology outpatient department with bleeding from the classical caesarean scar site cyclically during menses. Elective laparotomy with excision of uterocutaneous tract was done. Histopathology showed scar endometriosis.

CASE REPORT

A 28-year-old, P2L1 lady presented to our out patients department with complaints of bleeding from the classical caesarean scar site cyclically during menses for the past 2 years. She has had 2 prior classical caesarean section one was 14 yrs back, and another 10 years back. Her second caesarean was done for intra uterine fetal demise at 10 months of gestation. She does not have any prior co morbidities or significant family history. Her general examination was normal and vitals were stable (Figure 1).

During abdominal examination, a scar of about 5cm in length and 1 cm in width was seen extending from below the umbilicus to the suprapubic region, scar was contracted. A depressed area was seen in about midway of the scar site,
2×2 cm, shiny, smooth in nature where a nodule was palpable 1×2 cm was firm to hard in consistency. USG was done which showed a hypoechoic tract measuring 26 mm in length and 7 mm in width noted at the anterior abdominal wall in the suprapubic region extending from the incisional site of skin to deep abutting the anterior wall of the uterus with minimal vascularity noted suggestive of scar endometriosis. Wide local excision was planned under spinal anesthesia. Methylene blue test was done, dye was passed from the cervical os, dye came out from the uterocutaneous fistulous tract (Figure 2).

**Figure 2: Methylene blue dye test positive**

The uterine scar could not be visualized completely separately from the endometriotic fibrosed tissue, with adhesions present between bladder, anterior abdominal wall, bowel, parietal peritoneum. Endometriotic nodule 2 cm in length 2 cm in width, irregular margin, firm in consistency was excised from the previous uterine scar site. Adhesiolysis was done, uterine fistula was closed. Subcutaneous drain placement was done. Abdomen was repaired in layers (Figure 3).

**Figure 3: Fistulous tract in the uterus**

Patient was shifted to new post operative ward. Drain was removed on day 2 and the patient was discharged on day 3. She was followed up on day 7 with histopathology report which showed features compatible with endometriosis (Figure 4). Stapler removal was done on day 12. She was advised to avoid future pregnancy to prevent from recurrence.

**Figure 4: Photographs of Histopathology showing endometriotic glands and stroma of scar endometriosis (Magnification: 100X, Stain: H&E)**

**DISCUSSION**

Uterocutaneous fistula is rarely seen in clinical practice and usually occur after cesarean sections or other pelvic surgeries. Uterine fistulas occur more commonly with the urinary bladder and the bowel due to iatrogenic injuries, infections, and malignancies. There are some reported cases of uterocutaneous fistulas, the majority of them followed cesarean section.\(^3\) The diagnosis is usually clinical one when the patient present with cyclical bleeding with menses from the previous lower abdominal wound or chronic purulent discharge of pus or serosanguineous fluid. The injection of methylene blue through the cervix is very helpful when the diagnosis is not very clear, it shows the spillage of the dye from the wound in cases of patent fistulous tract as was done in our case.\(^3\) Imaging can be helpful in detecting the abnormal tract between the uterine cavity and the skin, magnetic resonance imaging (MRI) or CT scan with contrast agents are very helpful to define the anatomical planes in the pelvis. Fistulography or hysterosalpingography are also very informative which involve the injection of the water soluble contrast material through the skin opening or through the cervix and will demonstrate the abnormal connection between the skin and the uterine cavity.\(^4\) Hysteroscopy will visualize the abnormal tract directly. Our case presented 10 years after cesarean section due to the cyclical bleeding from caesarean scar site during menses. On palpation endometriotic nodule was felt, establishing scar endometriosis as a cause of uterocutaneous fistula.

The management of uterocutaneous fistula is a stepwise and involve careful assessment of the patients general condition, investigations to detect the underlying cause, the anatomy of the tract must be identified clearly before any kind of intervention, associated infection must be treated with appropriate antibiotics and drainage of abscesses, the best
surgical management involve excision of the whole fistulous tract with suturing of the uterine wall with an absorbable suture material same was done in our case. Follow up is recommended for early detection of any postoperative event and early intervention when required.

In summary, we discussed a case of scar endometriosis that developed a uterocutaneous fistula. This helps us in understanding the complication of caesarean section as scar endometriosis and utero cutaneous fistula independently or endometriosis leading to fistula. This highlights the importance of lower segment caesarean section as a cause of scar endometriosis and proper diagnosis and excision as a cure for the morbidity affecting the daily lives of some women. The limitation in our study was not using MRI as a diagnostic modality which is more accurate than ultrasonography. The reason for it being expensive and not available at our centre.

REFERENCES:


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