

Clinical Case Study

Entero-Uterine Fistula Repair

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Clinical Background

- Rape case of a full term pregnant women
- Serious post traumatic hemorrhage and genital injuries
- Necessitated an emergency cesarean section at an outlying clinic
- A significant hemorrhage during the C Section lead to the placement of two surgical sponges to achieve hemostasis through mechanical compression. These were inadvertently left in place.
- Post surgically the patient suffered from heavy vaginal lochia/drainage and sharp pains.
- Weight loss
- No fever or inflammatory signs
- Two curettage procedures were later performed in an attempt to stem the vaginal drainage without success
- Three months later the patient was transferred to St Vincent Medical Center for definitive care.

Exam on Arrival

- Patient was severely malnourished and anemic
- Heavy Vaginal Lochia
- A 15cm in diameter mass was adhered to the omentum in the left iliac fossa
- Abdomen was soft, but very tender in the right and left lower quadrants.
- A hypoechogenic irregularity on the lateral view of the uterus was seen with ultrasound

Surgical Exploration

Opening the Abdominal Cavity



Enlarging the sub umbilical incision



Exploration of the Visera

Dissection of a retro uterine and retro jejunal mass with adhesions



Exposure and exploration of a segment of jejunum with multiple perforations and adhesions



Exploration of Douglas Pouch and adjacent structures.



Lysis of Multiple Adhesions

Digital lysis of multiple adhesions to gain access to the lesions

Discovery of a large entero-uterine adhesion



Further lysis of adhesion and discovery of a communicating fistula between the ileum and uterine lumen. During dissection and lysis, two surgical sponges are discovered lateral to the Uterus



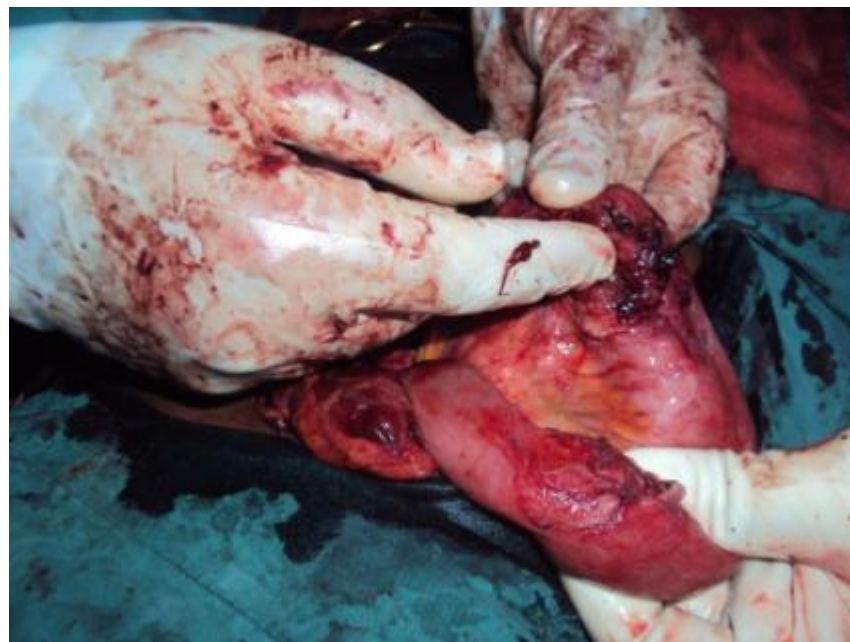
Exploration of the lumen of the ileum which was adhered to the uterus



Exploration of the enteral lumen



Lesions of the lumen secondary to perforations



Exploration of the vaginal orifice in search of communicating fistulas and exploration of a communication by Foley catheter, which demonstrated a fistula between the uterus and the perforated portions of intestine.



Digital Exploration of the Uterine Communicating Lesion

Introduction of a finger to explore the depth and diameter of the fistula orifice in the uterine fundus



Orifice in the back of the uterus to which the intestines were adhered



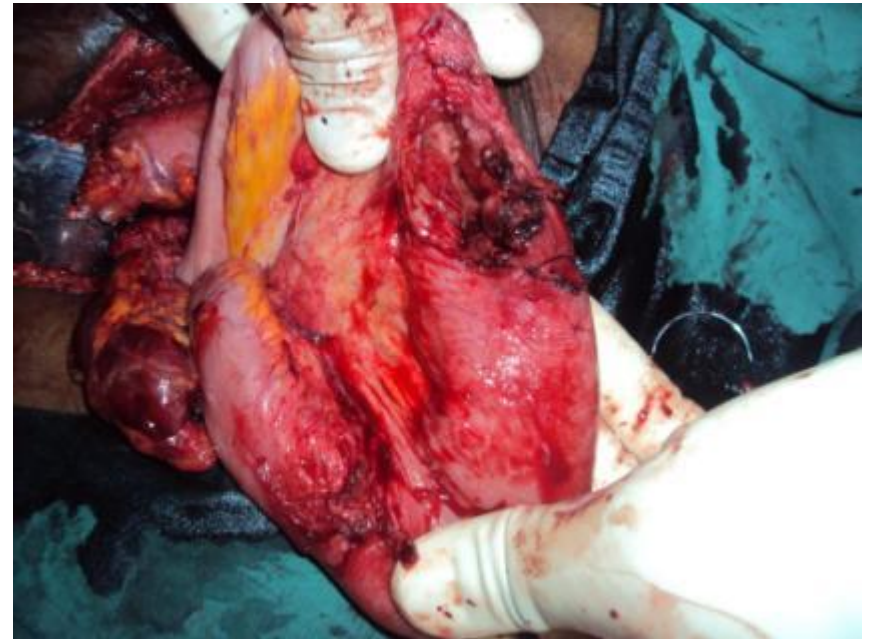
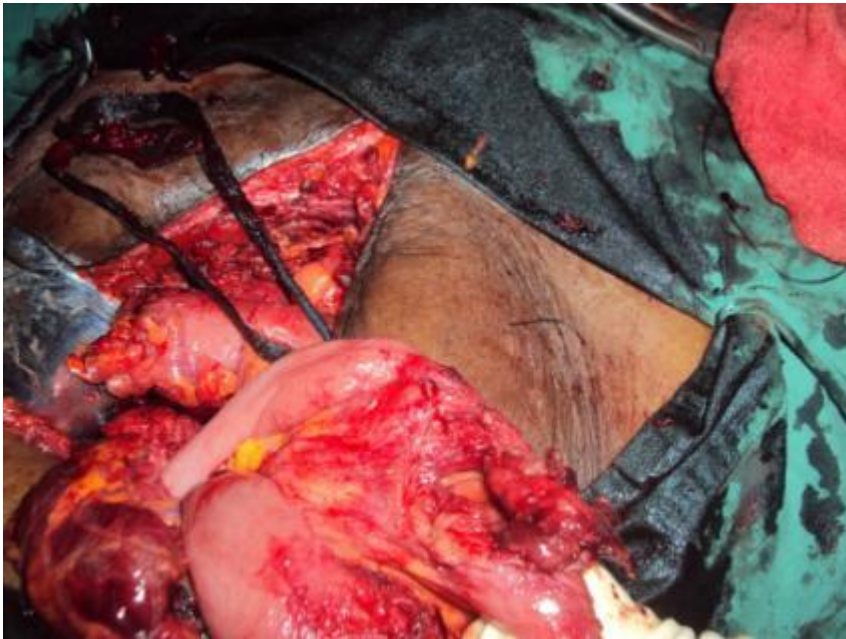
Exploration of the length of the small intestines to rule out Typhiod lesions and perforations



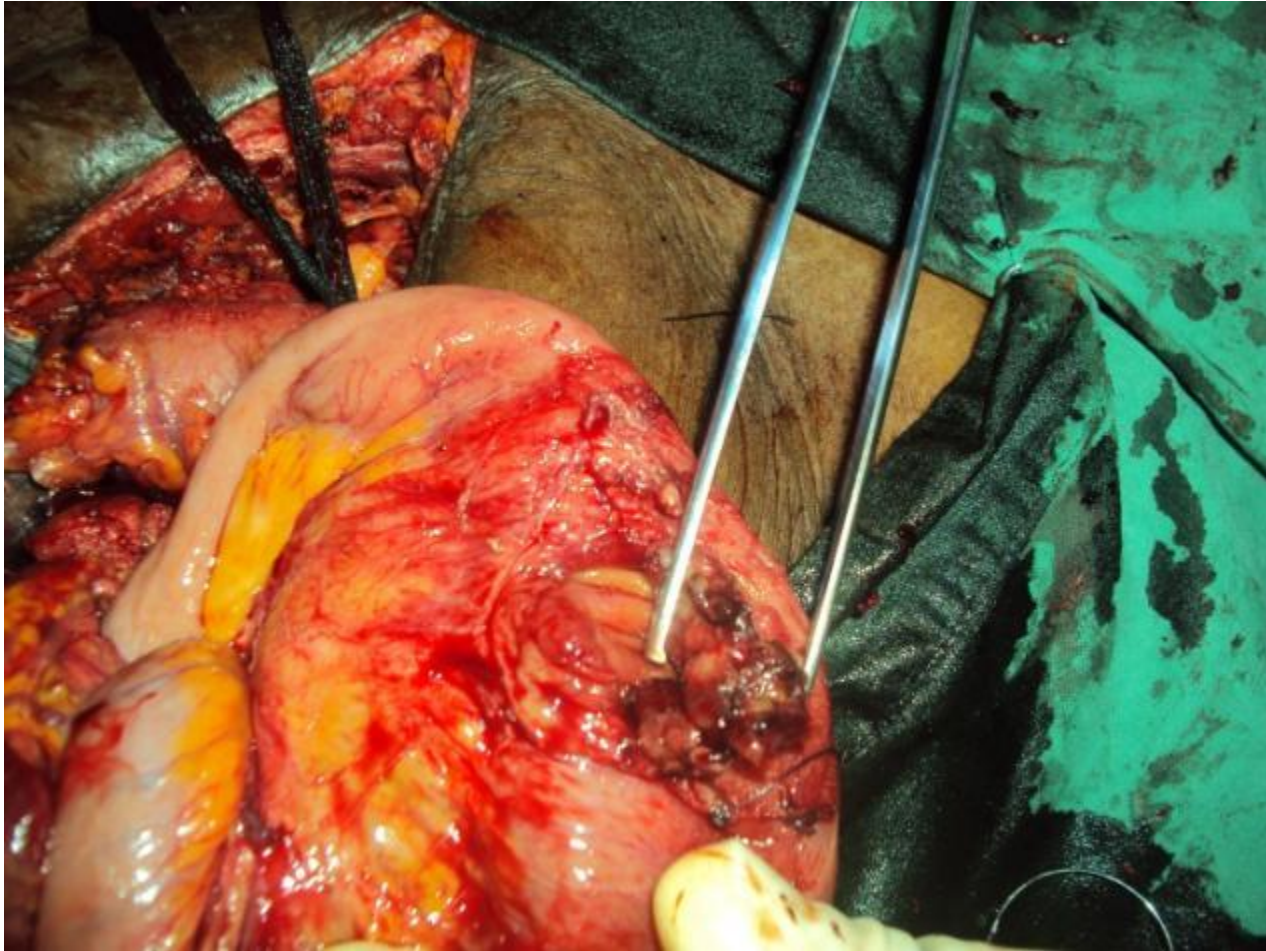
A perforation of the small intestines which was adherent to the uterus with an endometrial communication

Exploration of the orifice and perforations

lesions

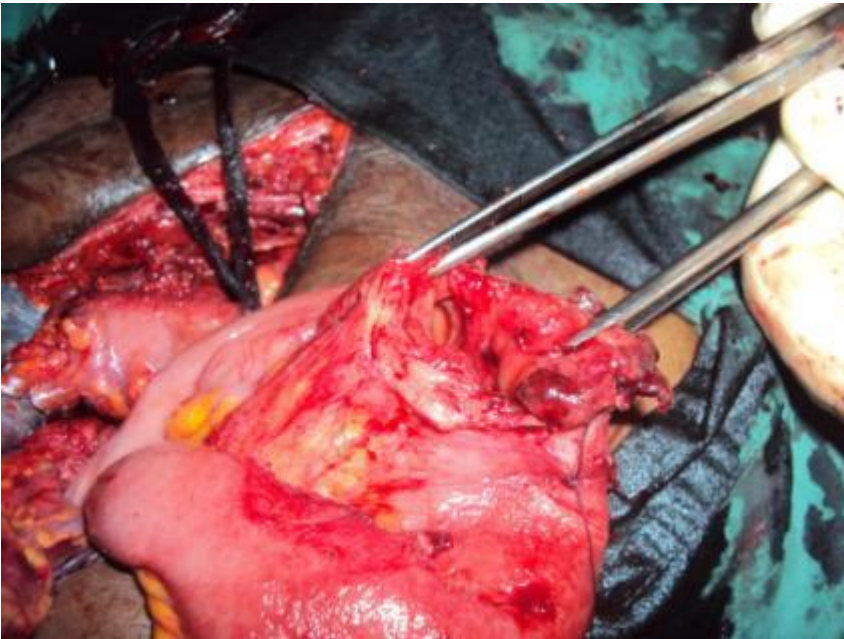


Lesions

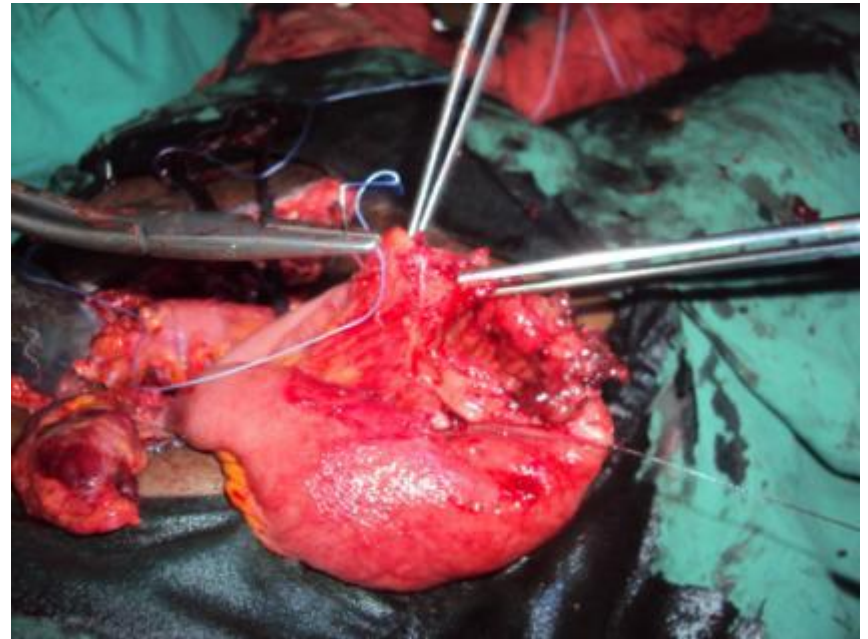


Repair of the small intestine

Excision of necrotic tissue around the perforations

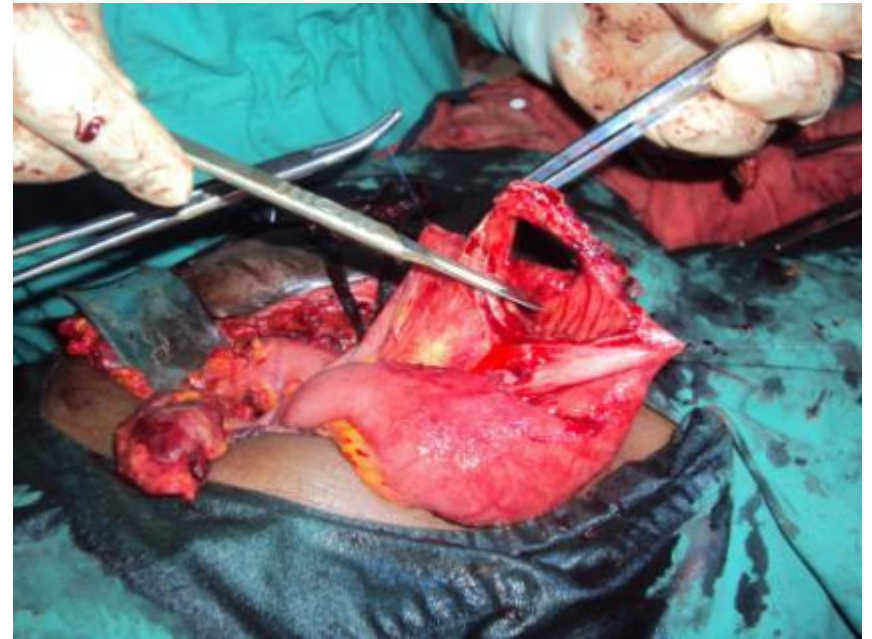


Placement of a traction suture to allow better visualization and suturing of the intestine



Excision of necrotic tissue on the exterior of the intestine to allow better scarring and healing

Same



Repair of the Small Intestines

Simple interrupted absorbable sutures are used to repair the intestinal wall



Suturing the intestinal perforations



Suturing the Intestinal Wall

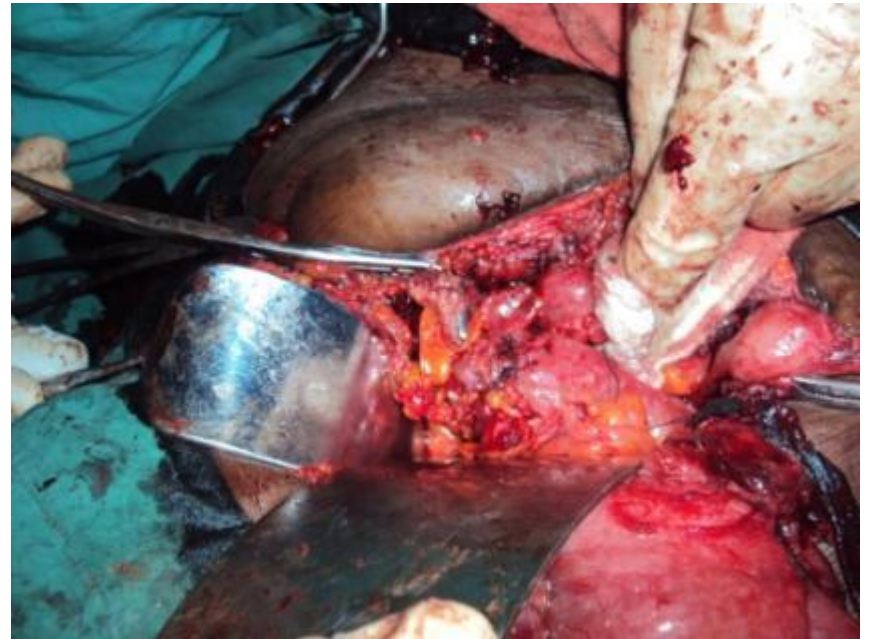


Two layer repair of the uterine wall after removal of necrotic tissue and edge revision.

Tying of surgical knots during wall repair



Wall repair with 0 Vicryl suture



Identification of a 20 cm segment of the jejunum, which is perforated in several spots by untreated salmonella typhoid lesions



Resection of the mutiperforated section of Jejunum

Resection performed between two surgical clamps

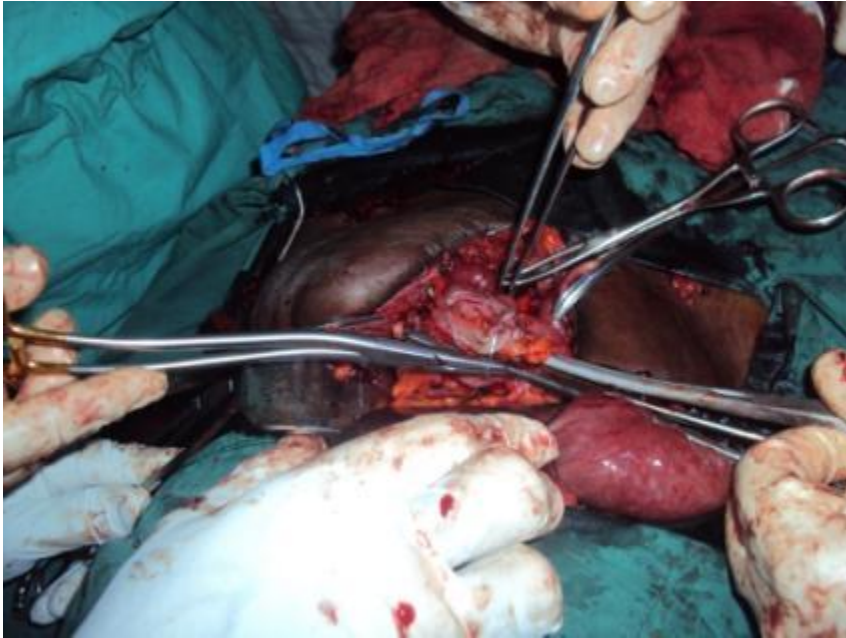
The resected portion of jejunum is place on a table, next to forceps



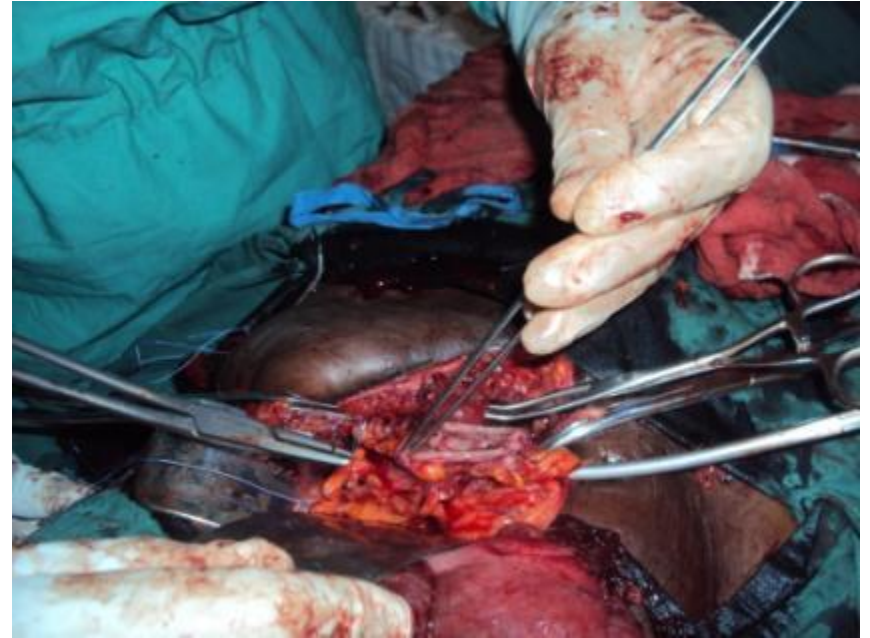
The two sections of intestines are brought together in preparation for a terminal anastomosis



Terminal Anastomosis of the Jejunum



Next



Re establishment of Intestinal Continuity



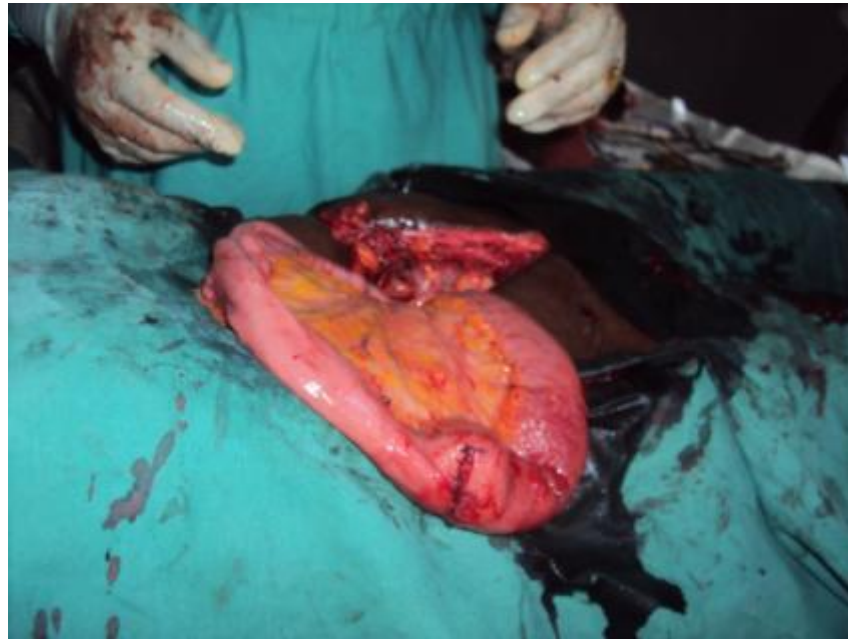
Re establishment of Intestinal Continuity

Two layer closure of the intestinal wall

suturing of the terminal portion of the jejunum



Finally!!



Irrigation of the peritoneal cavity with two liters of lukewarm physiologic fluid (Lacted Ringers)



Cleaning with 50ml of Ciprofloxin before closing



Placing a drain in Pouch of Douglas



Closing the Abdominal Wall



Surprise!!!!

Two surgical sponges from the previous Cesarean section are found during surgery

The two surgical sponges found in the peritoneal cavity ,along side the resected piece of Jejunum



The patient three days after surgery. She is pictured with her baby born of the botched
Cesarean section three months prior.

She is 50 year old and mother of five Children. She is a farmer. She final can live
without pain or vaginal drainage.

