Spontaneous Enterocutaneous Fistula – A Rare Presentation

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Citation

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Abstract

Spontaneous perforation of the intestine through the abdominal wall is an extremely rare condition. We encountered a case of spontaneous enterocutaneous fistula through the anterior abdominal wall in the right inguinal region. In view of the rarity of this complication and the paucity of published articles, a case report pertaining to spontaneous enterocutaneous fistula is being presented here.

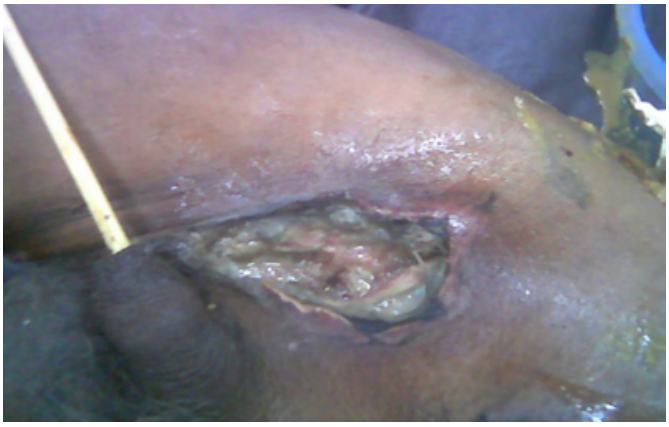
CASE REPORT

This is a case report of a 60-year-old farmer who developed a spontaneous enterocutaneous fistula in the right inguinal region. He presented in the surgical emergency ward of CSMMU with the complaints of pain in the abdomen, fever, localized pain and swelling in the right inguinal region and absolute constipation; later he had developed a wound in right inguinal region with feculent discharge through its centre.

There was no history suggestive of previous inguinal swelling or previous surgery. On examination, findings were suggestive of acute peritonitis. The patient had distended abdomen with guarding and rigidity with masked liver dullness on percussion. There was discharge of fecal matter through the wound. This wound of the size of 5x5cm was situated in the right inguinal region and right lower abdominal wall (fig.1). The patient was toxic, had high temperature (101°F) and tachycardia (100/min). X-rays of the abdomen in erect posture showed gas under the diaphragm.

Figure 1

Figure 1:Wound at the time of admission showing a spontaneous enterocutaneous fistula in the left inguinal region.



After intravenous fluids, antibiotics, and blood transfusion the patient underwent explorative laparotomy. This reveled that the distal ileum was attached to the posterior surface of the anterior abdominal wall with a perforation of 0.5cm. There were three more perforations about 6” proximal to the ileum adherent to the abdominal wall, the bowel in between was looking normal. Resection of the perforated segment of the ileum was done with double barrel ileostomy and extensive debridement of the gangrenous patch of abdominal wall and inguinal skin. The resected bowel segment and parietal contents were subjected for histopathological examination and findings were consistent with non-specific inflammation.

DISCUSSION

In the above mentioned patient there was no history suggestive of any kind of hernia or previous swelling in the inguinal region. A spontaneous fistula arises in patients with inflammatory bowel disease, radiation enteritis, diverticular disease or intestinal tuberculosis. A surgical intervention is regarded as one of the major causes of development of fecal fistula in adults. Few cases of the pediatric age group with incarcerated inguinal hernia developing a fecal fistula have been reported. Incision of hernia or other interventions by quacks have been reported as causes of fecal fistula in adults. None of these interventions was observed as cause of fecal fistula in our patient.

CONCLUSION

A detailed clinical history of the patient regarding possible etiologies for the development of such fistulae should be sought after to clinch a proper diagnosis. The absence of prior surgery, features suggestive of intestinal tuberculosis and the other mentioned etiologies made the above case a rare presentation. The presence of intra-abdominal infection leading to an abscess that ruptured internally into bowel and externally through the skin could be the possible sequence of events explaining this presentation.

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