

A Fecal Fistula - Still a Social Stigma

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Abstract

Fecal fistula is a common intricate condition that a surgeon faces in his/her clinic or OPD (out-patient department). It requires accurate and focused clinical management to treat it. After identifying its cause, management of fecal fistula is not only clinical as it also involves a social stigma, especially in rural Indian population. We have come across a similar situation where rehabilitation of our patient with fecal fistula needed extensive peri-operative counseling with the family of the patient so as to save her place in her in-laws house. We like to focus and report this slightly unattended special aspect of fecal fistula at our institute.

CASE HISTORY

A 21-year-old married Hindu female hailing from rural India came to OPD with fecal discharge from her operation site for one year. The patient underwent caesarean section one year back at her native place, one week after which she started having this fecal discharge. She took treatment for two months, but it did not heal. Finally, she came to Mumbai with her sister for further management.

On examination, she was an emaciated young female with two openings at her operation scar. The central opening was larger and was draining fecal matter while the lateral one was smaller and with sero-sanguinous discharge.

Figure 1

Figure 1: Two openings on the scar, the main one with fecal discharge



There was no history of tuberculosis or contact with

tuberculosis. She gave a history of bloody discharge from her lateral opening during her menses, which started eight months postoperatively, complicating the situation further. Her periods were irregular and scanty. She was also passing some amount of gas per-rectally. Per-vaginally and per-rectally there was no internal opening seen or felt.

On investigating, her hemogram showed: HB: 6.9gm%, TC: 9100 cumm and Creatinine: 1. X-ray of the chest: WNL. Ultrasonography of abdomen and pelvis showed clumped bowel loops in the pelvis and minimal internal echoes just beneath the fistula tract, the rest of the viscera being normal including her uterus and adnexae. The patient had an albumin of 2.2 with altered albumin-to-globulin ratio.

A fistulogram was performed which showed a sigmoid colon-cutaneous fistula with a small collection in between and no dye entering into or around the uterus.

Figure 2

Figure 2: A fistulogram being performed



First, a decision was taken to build the patient. Two units of packed red blood cells were transfused and TPN was given to the patient. Even after two weeks on this treatment, the fistula persisted. After thorough gynecological evaluation, a decision to perform an exploratory laparotomy was taken for closure of fistula with defunctioning transverse colostomy. A detailed counseling of the patient along with her relatives was done. Her husband and in-laws did not come for the counseling even after persistent request.

At exploration, there was a sigmoid colon-cutaneous fistula, which was excised and sent for histopathology. The uterus was normal with few adhesions with fundus and anterior part. After meticulous adhesiolysis, colostomy was performed and abdominal lavage was given with warm normal saline. A tube drain was put in the pelvis for 5 days. Postoperative recovery was uneventful. The colostomy was closed after 6 weeks.

Meanwhile, the patient and her relatives available were taught colostomy care. Her husband did visit her in hospital after our persistent request but simply refused to accept her home with colostomy even after counseling. The patient was living with her mother till colostomy was closed and was under severe mental stress, agony and depression. She needed repeated psychiatric evaluations to stabilize her during this period. Only after her colostomy was closed and all wounds healed completely she was taken in her in-laws house. Histopathology report was tuberculosis with scar endometriosis, which responded to conservative treatment.

Figure 3

Figure 3: Freshly prepared loop transverse colostomy with retaining catheter



DISCUSSION

The commonest etiological factor for formation of fecal fistula is an abdominal operation (1). A few operations following which we encounter colo-cutaneous fistulas are laparotomy for infected pancreatic necrosis, left colonic resections (especially low anterior resection), intestinal resection for gangrene of intestine, closure of colonic perforation, difficult adhesiolysis, difficult hysterectomy, difficult nephrectomy, etc. Incidences are higher during a second or redo surgery and are highest during laparostoma.

Colonic injuries were also discerned following laparoscopic pelvic surgery. Cautery burns to colon are more likely with use of monopolar than bipolar cautery. Recently, colonic fistula has also been reported following percutaneous drainage of abdominal abscess. Colovesical or colovaginal fistula may develop following Wertheim's hysterectomy, L.A.R., etc. Spontaneous fistulisation due to disease occurs usually into an internal organ.

Predisposing factors for postoperative fistula are local, regional and general. Local factors are tension on bowel ends, poor local vasculature (devitalisation) of margins, specific diseases at cut ends, local infection, etc. Regional factors are abscesses, distal bowel obstruction and acute necrotizing pancreatitis. General co-morbidities, which predispose to the fistula, are acute catabolic illness (like acute necrotizing pancreatitis), severe malnutrition (with serum albumin less than 2g%), marked diabetes mellitus, morbid obesity, prolonged steroid therapy, etc.

Classification of fistula: According to output in 24 hours, the

fistulas are classified as high output, >100 ml per day, or low output, < 500 ml per day. According to the anatomy, single simple fistula (one, single, direct, tract between bowel and skin or another viscus), branched fistula (single opening in bowel with multiple tracts and two or more openings on the skin) and multiple fistulas (multiple openings in bowel at different sites) are discerned.

Problems encountered in colo-cutaneous fistulas (2,3):

Bacterial contamination of usually sterile areas, which is encountered in 75% of cases; “loss of digestive juices” due to bypass of variable length of bowel and thus impaired digestion and absorption; fluid and electrolyte imbalance due to loss of intestinal juices(4); secondary infection of the wound if the fistula tract goes through the main wound; and skin excoriation by various digestive enzymes.

The sequential management considerations are (3): fluid and electrolyte balance, skin protection, nutritional support, pharmacological treatment, ultrasonography or CT scan of the abdomen to look for any collection or abscess, contrast radiology (fistulogram) to exactly localize the fistula and to study its local anatomy. Surgery: early? Or delayed? Or not at all?

Prognosis depends upon various factors: site of fistula: small intestinal high-output fistulas can carry a mortality up to 15%, while left colonic ones carry no mortality and have better prognosis. The higher the output, the worse is the prognosis (3). Multiple and complex fistulae have bad prognosis. Advanced age and poor nutritional condition worsen the prognosis.

So far, we have discussed the standard routine of fecal fistula. The most important aspect is a meticulous pre- and postoperative counseling of the patient and the relatives not just about colostomy but also as a patient in whole. If this is not done perfectly, postoperative mental breakdown of patient is imminent. Even worse is non-acceptance of the patients by their family members. Couple counseling is very important. Unfortunately, this aspect is not given enough importance most of the time, which is an absolutely crucial factor, mainly for the rural Indian population, who carries some fixed arbitrary misconceptions regarding this

pathology and especially towards colostomy, mainly due to lack of knowledge and awareness. At many centers, a professional counselor does this counseling. Colostomy care centers teach patients and their relatives about colostomy care.

The treating surgeon has hardly any time towards this issue either because he/she is busy elsewhere or just ignores its importance and hand it over to their juniors to do the needful. Juniors, again unaware of its social and familial implications, just “touch” the issue. The results are, as expected, quite devastating for patients, mainly for females; a few end up committing suicide. So what has one achieved by performing just brilliant surgery? - A dead patient, not because of technical limitations but due to simple apathy towards the simple, yet very powerful art of counseling. Thus, this is a message to every surgeon: “do not rely on others but do the counseling yourself”. Together, we can save a precious life and break a social stigma.

Counseling thus helps a surgeon to have a good rapport with patient, keeps him/her safe from medico-legal problems, heals patients physically and mentally and relatives understand that this is no more a social stigma. We would like to emphasize this slightly unattended common issue, which saved our patient’s position in her in-laws house.

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