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Case Report

Entero-cutaneous fistula: an unusual complication of suprapubic cystostomy

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Abstract

Supra-pubic cystostomy, often done to relieve urinary retention or protect a bladder outflow reconstructive surgery, is often considered a "simple" procedure by all standards. The complications following this procedure are few, being limited to haemorrhage and bladder collapse with difficulty in identifying intra-operatively, especially in closed cystostomy. Uncommon complication includes bowel injury.
We report on a patient who presented with entero-cutaneous fistula following supra-pubic cystostomy (SPC). He had right hemicolectomy with ileo-transverse anastomosis and repair of cysto-cutaneous fistula.

Case Report

A 70year old Fulani businessman was referred from a peripheral Hospital to the surgery department of Federal Medical Centre (FMC), feacal leakage through a suprapubic cystostomy catheter(SPC) and a burst abdomen . He had urinary diversion by suprapubic cystostomy in the referral Hospital to relief acute retained urine and failure to pass a urethral catheter. There was antecedent history of obstructive and irritative urinary symptoms for the past 11 years associated with recurrent urinary retention usually managed by successful urethral catheterisation. The patient re-presented in referral Hospital two weeks following discharge with fecal leakage through the wound and the supra-pubic catheter which was purportedly placed in the bladder. He had exploratory laparotomy, at that hospital ,and findings were multiple perforations created at adhesiolysis of ileum at 7-10cm from the ICJ. Ileostomy was done and SPC catheter repositioned. He had a repeat burst abdomen and was referred to FMC Gombe.At presentation he was chronically ill, anaemic, malnourished, dehydrated with generalized debility.The pulse rate was100/min and blood pressure was 100/70mmhg.
Abdominal examination revealed an infra-umbilical surgical wound filled with urine mixed with greenish dark semi-formed stool and functioning ileostomy in the right iliac fossa. The prostate was not clinically enlarged. An assessment of burst abdomen with complex entero-cutaneous fistula was made. Patient was resuscitated anemia corrected with whole blood and Hypokalaemia corrected. He was deemed nutritionally rehabilitated and had exploratory laparotomy. A cysto-sigmoid was noted with total transection of the terminal ileum, 10cm from the ICJ .The fistulous tract between the bladder and the sigmoid was walled off from the peritoneal cavity by thick bands of fibrous adhesions. He had right hemicolectomy with ileo-transverse anastomosis..The sigmoid –vesical defect was repaired and the bladder drained by a urethral catheter .
Postoperative the patient was very ill but gradually recovered and was discharged after 2 weeks on admission and has remained well.

Discussion

The bladder is mainly an extra-peritoneal pelvic organ with the peritoneal reflection at the dome and upper part of the anterior surface which is reflects upwards to the dome as the bladder fills with urine, thus stripping off the peritoneum from the anterior surface of the bladder this simple looking anatomic situation may be distorted where there is fibrosis from previous laparotomy, previous suprapubic cystostomy and chronic pelvic inflammatory disease in females. In these situations cystostomy may be very complex and atttention to detail and deliberate and careful dissection will be enough to avoid placing the cystostomy tube in the gut.

In this patient the situation was made worse by the continuous drainage of the bladder into the peritoneal cavity and this denies the surgeon the advantage of a full bladder that may make cystostomy easier. It is important to be very acquainted with vesical anatomy so that if one inadvertently finds himself in gut lumen it could be identified

Conclusion

Cystotomy placement following a previous cystostomy can be a tasking job and attention to detail soon finds one through with good anaesthesia theatre lighting and attention to detail.

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