Recommendations for Surgical Management of Colouterine Fistula

MacMillan, M[1], Rao, J[1]
[1]Department of Obstetrics and Gynaecology, Osborne Park Hospital, Osborne Pl, Stirling WA 6021

Case description:

We describe a case of a an 88-year-old Caucasian woman with a history of moderate sigmoid diverticular disease who presented with 12 months of passing flatus and faeces through her vagina and chronic left iliac fossa pain.

CT abdomen with portal venous contrast revealed a colouterine fistula involving the distal sigmoid colon and uterus. There was contrast and multiple gas locules within the uterine cavity, and circumferential thickening of the sigmoid colon with fat stranding. There was no abdominal or pelvic lymphadenopathy or solid organ metastasis.

She was referred to a tertiary colorectal unit. She underwent a laparoscopy which found the sigmoid colon was adherent to the posterior aspect of the uterus, and a chronic abscess fistulating from the colon to the uterus, secondary to suspected diverticular disease. An uncomplicated anterior resection was performed to remove the diseased sigmoid colon. The uterus was left in situ.

The patient had to be re-operated on and suffered from post-operative complications including adhesional small bowel obstruction, volvulus, and ischaemic bowel, and died several months after the initial operation.

Discussion:

Colouterine fistula is a rare condition due to the low risk of fistula formation through the thick myometrium.[1]
First reported in 1909, [2] there have since been 42 cases published in the literature. Management described in the literature is with hysterectomy and bowel resection. [1,3]

In this case, the patient underwent an anterior resection in a tertiary center that does not have a gynecology service. Intraoperatively she was found to have a chronic fistulating abscess between the colon and the uterus, however a hysterectomy or washout of fecal content from the uterine cavity was not performed. The patient suffered from multiple post-operative complications including adhesional bowel obstruction. In cases of colouterine fistula, the uterus contains fecal matter, and is a nidus of infection. In such cases, we recommend treatment with hysterectomy, in addition to bowel resection, under the management of a multidisciplinary team.

The barriers to multidisciplinary care in this case may include a breakdown in communication between the treating team and another tertiary center which provides gynaecology consultations to them. Both services are located at different sites. Multidisciplinary meetings involving colorectal and gynaecology teams may have averted the mortality.

References:

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