A Case of Hepato-Gastro Cutaneous Fistula

UNIT- 2 GENERAL SURGERY

CASE REPORT-

- A 35 year old female patient came with complaints of pain in upper abdomen since 2 months associated with watery discharge from the wound present over a midline scar
- No h/o fever
- No h/o nausea ,vomiting
- No h/o any bowel or bladder complaints

Past history-

- O/C/O epigastric hernia with anatomical repair 8months back
- No Co morbidities

Family history-

- Not significant

Obstetric history-

- P1L1(FTVD/Male/16yrs)

Personal history-

- Diet- mixed
- Sleep and appetite-Normal
- Bowel and bladder- Regular
- No addictions

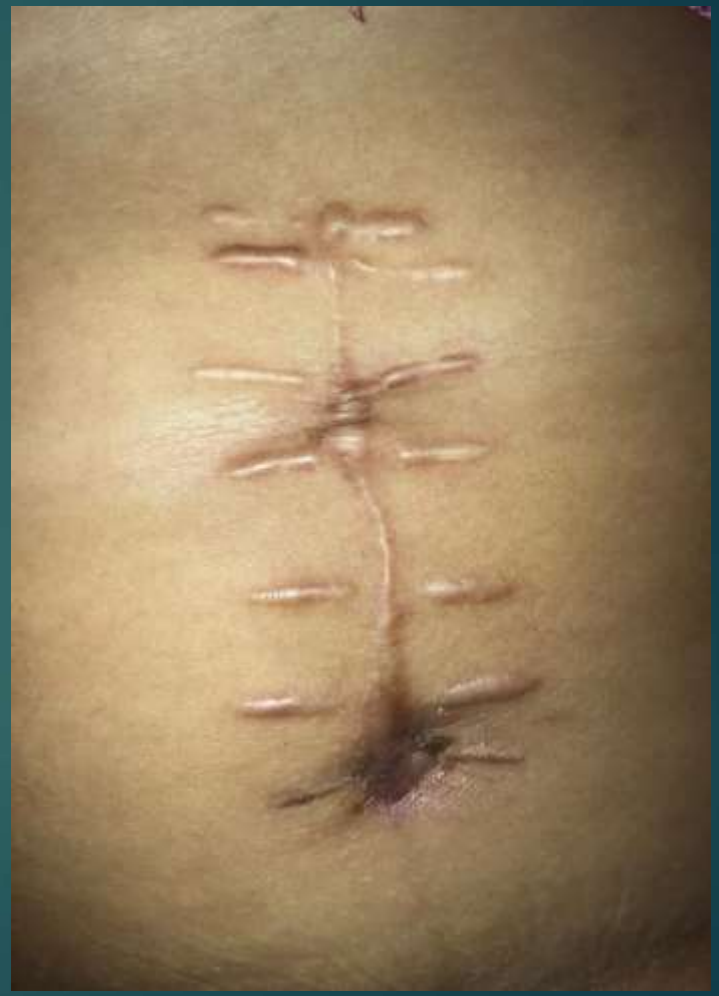
General examination-

- Afebrile
- PR- 82/min
- BP-110/70mmhg

- **PA**- Soft, non-tender
  No guarding
  No organomegaly
  No palpable mass
  Bowel sound present in all the quadrants

LE- e/o ~7cm midline supraumbilical scar

- 0.5*0.5cm sinus noted at the caudal end of scar,
- minimal seropurulent discharge present
- no local rise of temperature ,no tenderness, no bogginess, no cough impulse.



Systemic Examination-

- CVS- S1,S2 present, no murmur
- RS- Air entry bilateral equal
- CNS- No neurological deficit

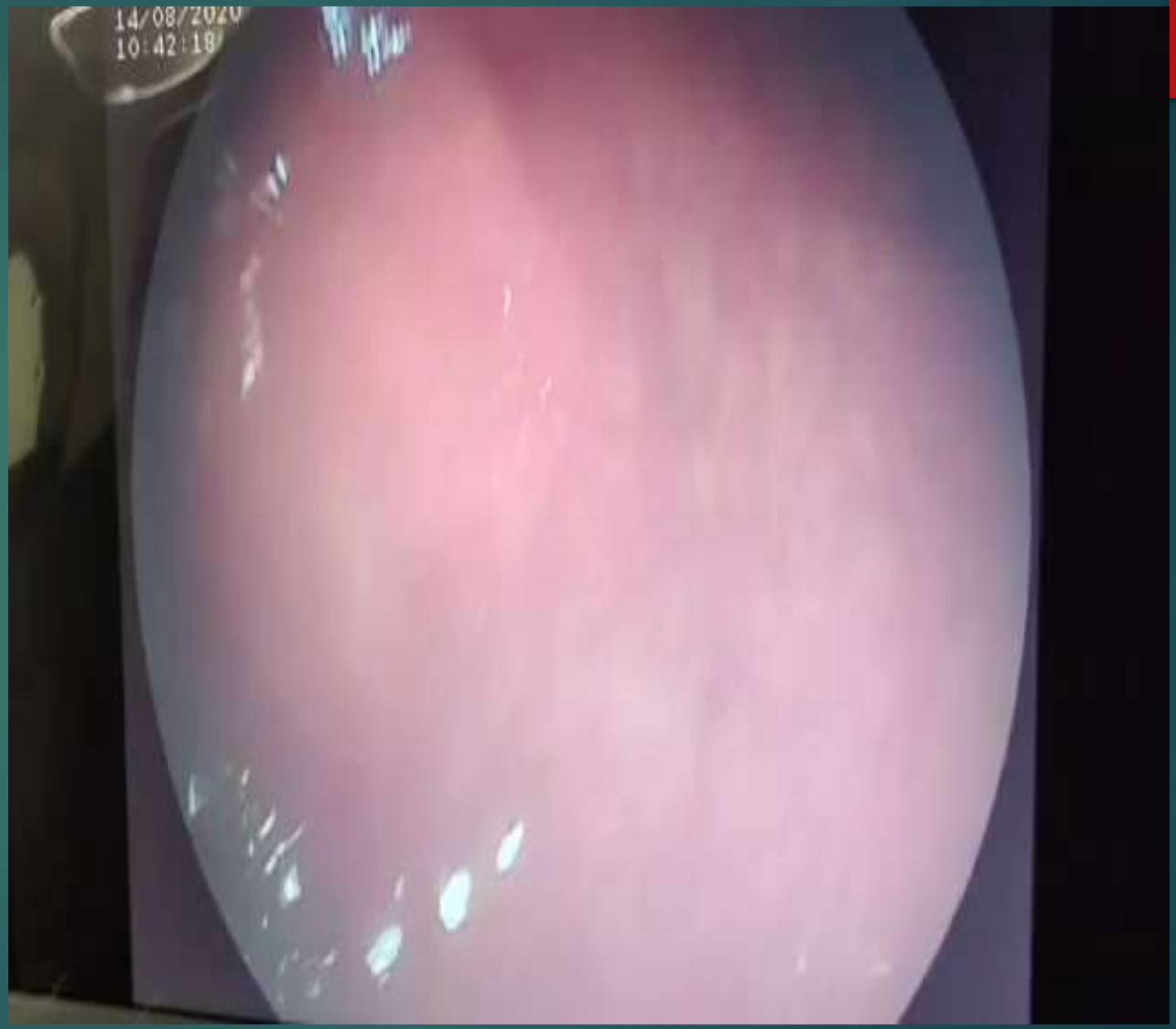
INVESTIGATIONS-

- Patients all routine labs were within normal limits
- **USG(A+P) 11/8/2020** –

- e/o sinus tract ~9mm in width and ~8cm in length in the subcutaneous plane,
- extending from the lower end of the scar in the epigastric region to the left lobe of liver
- S/o chronic hepato-cutaneous fistula.

- **CECT(A+P) 12/8/2020-**

- Fistulous tract extending superiorly and posteriorly from the caudal end of the scar over a length of 31mm up to linea alba
- On the right of the midline it is coursing superiorly and posteriorly over a length of 20mm up to anterior wall of stomach
- Further, the tract is extending superiorly up to anterior surface of left hepatic lobe adjacent to ligamentum teres over a length of 30mm
- Inferiorly the tract is extending over a length of 25mm and opening into gastric lumen near gastric antrum with leak of the contrast into the stomach.
- S/O cutaneous hepatic-gastric-fistula



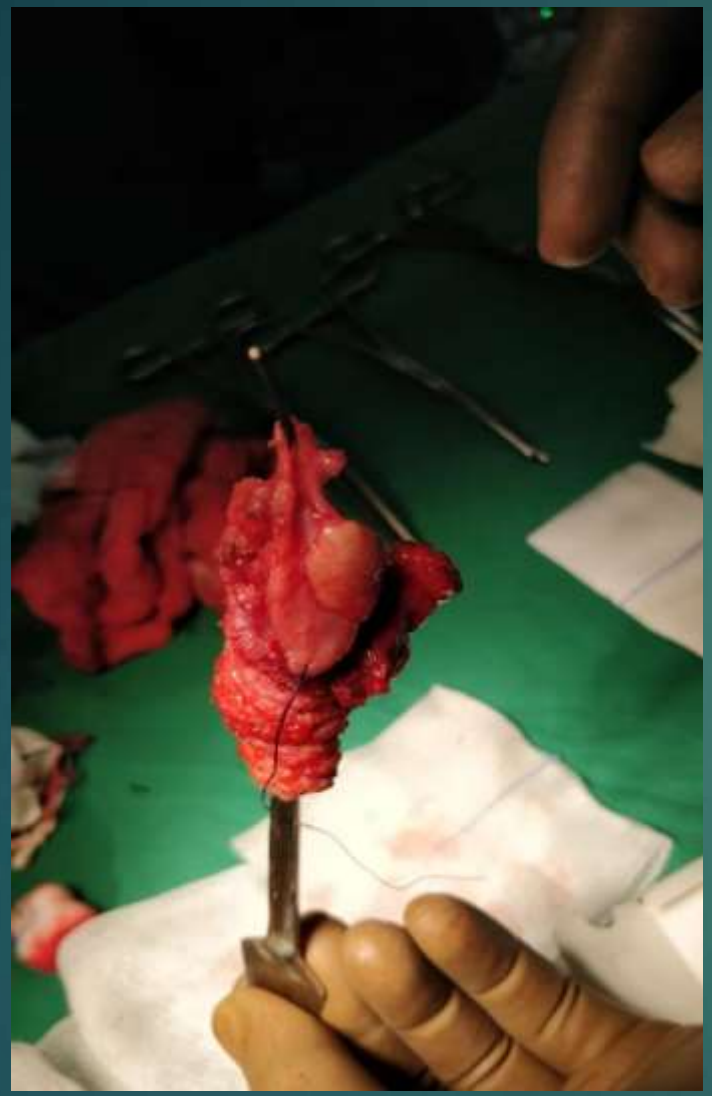
Gastroscopy
14/8/2020-

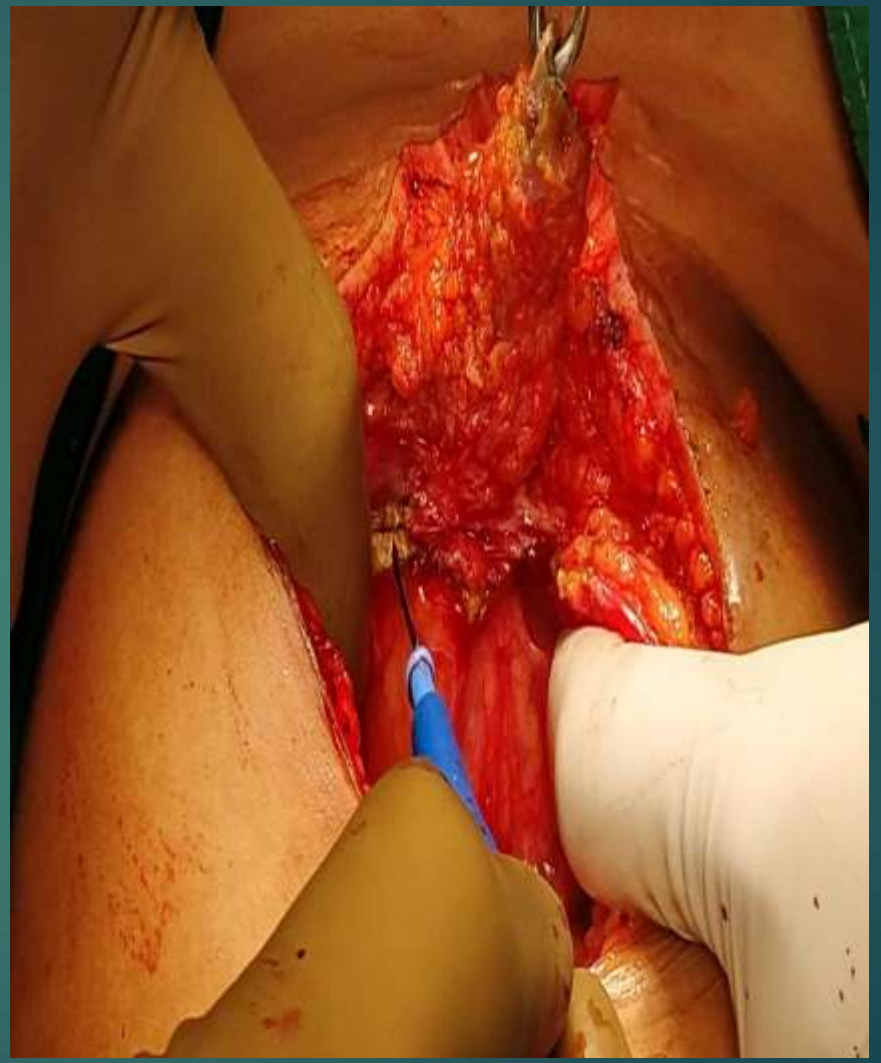
e/o dye(methylene blue) leak through the anterior aspect of pyloric antrum ~2-3cm proximal to the pyloric canal

MANAGEMENT-

- Intra-op findings-
- Incision taken above umbilicus including external opening at distal end of scar
- Incision deepened up to peritoneum
- e/o 8cms fistulous tract present extending from skin to capsule of liver(left lobe, inferior surface) up to antrum of stomach(anteriorly)

- Tract incised in-toto and send for HPE and CBNAAT
- Wedge resection of stomach(antrum) done at the site of fistulous opening
- Intra-op gastroscopy done to confirm complete excision of tract-no e/o any other opening
- Abdomen closed in layers
- Sterile dressing done
- Procedure uneventful





Fistulous tract

- **Histopathological findings-**

- Excised specimen of tissue from liver capsule- e/o fibro adipose and fibro collagenase tissue

- Excised specimen of fistula -features consistent with fistula, no necrosis, no atypia, no malignant features seen, ZN stain negative for AFB

- Other specimens-

- CBNAAT- detected for tuberculosis

  patients started on anti-tubercular drugs

  category DSTB-CP(A) for 6months

- Post surgery patient kept on follow-up and called for regular dressing, suture removal was done on POD-11

- Post suture removal- healthy scar present

  no discharge

DISCUSSION-

- **INCIDENCE-**

0.02-0.21%

- A fistula is defined as an abnormal communication between 2 epithelial surfaces.

ABDOMINAL TUBERCULOSIS-

- It is the 6th most common type of extrapulmonary tuberculosis

- Constitutional symptoms-
- Low grade fever, malaise, night sweats, anaemia, weight loss
- Observed in 30% of patients

- Atypical presentations-
- Lower GI bleed, fistula-in-ano, GI fistulas, perforation

GASTRIC TUBERCULOSIS-

- Most patients present with intermittent epigastric discomfort
- Vomiting
- Weight loss, fever

TUBERCULOSIS OF SMALL INTESTINE-

- Ulcerative
- Hyperplastic

PERITONEAL TUBERCULOSIS-

- It is thickening and fibrosis of the peritoneal wall which is studded with multiple tubercles

- WET type- common(95%) with formation of different types of ascites
- DRY types- shoes typical fibrosis and adhesions
- ASCITIC form- shows enormous distension of abdomen with dilated veins

- Tuberculosis of liver-

- Miliary type, granuloma/tuberculoma, liver abscess, obstructive jaundice

- Tuberculosis of pancreas-

- Miliary TB
- Presents as acute or chronic pancreatitis
- Pancreatic mass or abscess

CHALLENGES FACED IN MANAGEMENT OF TB RELATED FISTULAS

- Multiple branching of the fistulous tract
- Recurrence
- Abscess formation (intraperitoneal)

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THANK YOU