Faecal contamination during abdominal hysterectomy without bowel injury - A case Report

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Abstract: The incidence of bowel injury during abdominal hysterectomy and faecal contamination of surgical field is uncommon. We report an unusual case of a 34 year old woman who had abdominal hysterectomy for submucous fibroid and had faecal contamination without bowel injury during abdominal hysterectomy. A conservative approach consisting of thorough washing of the surgical field and prophylactic broad spectrum antibiotics is acceptable. A routine preoperative check to make sure the patient has passed stool before taking up for surgery and careful positioning of the patient for surgery are the keys to avoid this complication.

Keyword: bowel injury, abdominal hysterectomy, faecal contamination, without bowel injury.

Introduction
Abdominal hysterectomy is a common gynaecological surgery. It is associated with minor to major morbidities and mortality(1). One of the complication is faecal contamination of the surgical field which usually occurs after bowel injury. The bowel injury though is uncommon, injury to the rectum or to the ascending or descending colon can occur(2). The overall rate of injury to the bowel is 0.3% for AH(3). Faecal contamination can also occur without bowel injury. It is a unique experience report where the faecal contamination occurred through the vagina retrogradely after passing semi solid stool during surgery.

Case presentation
A 34 years old multiparous lady with history 2 previous LSCS who presented with complaints of spasmodic dysmenorrhoea and menorrhagia was diagnosed to have submucous fibroid polyp. She underwent hysteroscopic myoma resection under general anaesthesia. There was a type 1 submucous fibroid with abroad base measuring 3X3.5 cm arising from the left posterolateral wall of the lower uterine segment. The surgery and postoperative period was uneventful and she was discharged. 3 weeks later she presented with the same complaints. On examination uterus was normal size. A transvaginal imaging showed persistent submucous fibroid polyp 2X2 cm in size. She was given the option of repeat hysteroscopic resection or hysterectomy. She opted for hysterectomy. As routine protocol of our institute, preoperatively she was prepared with tablet dulcolax suppository 200 mg rectally the previous evening. It was recorded in the chart she passed stool one hour after inserting dulcolax. She was kept nil per oral since midnight. Next day, she underwent total abdominal hysterectomy. One dose of inj. cefazoline 1 gm IV was given as prophylaxis at the time of skin incision. Intraoperative finding was a normal size uterus with both tubes and ovaries normal. There were no significant adhesions. Extravascular hysterectomy was performed in the usual fashion.

The uterus was placed on traction cephalad, and the lower uterine segment and upper vagina were palpated between the thumb and first finger of the surgeon’s hand to ensure that the ligaments have been completely incised. 2 Hinneys clamp were applied from both ends and the vagina was cut across with a scissor above the clamp. As soon as the uterus was removed, faecal matter started pouring out from the middle part of the vaginal cuff. Suction was done immediately and cuff was closed with allies clamp. Despite vigorous effort, there was mild contamination with faecal matter of the surgical field. Rest of the faecal matter was suctioned out carefully opening the Allies clamps. Care was taken not to spread out the contamination by using surgical mops and suction. Washing with warm normal saline was done thoroughly2-3 times. The surgical field was checked thoroughly for any injury to small bowels and large bowels including rectum which could have occurred unknowingly during dissection of the POD. Any injury in the POD was checked. After a thorough check, it was concluded satisfactorily that there was no injury to bowel or the POD. Moreover as the surgery went smoothly without any untoward incident, any kind of unintended injury was not suspected.

The vaginal vault was closed with vicryl 1-0 after surgical field was satisfactorily clean. After closing the vault, the surgical field was washed thoroughly again 3-4 times with warm normal saline. Abdomen was closed in the usual fashion. After the surgery was over, it was noted that her thighs were placed closely together and she had passed semi solid stool. It was obvious that, due to very close approximation of the thighs,
A semi-solid stool had made way retrogradely towards the less resistant vagina though the parous introitus. Postoperative, she was started on intravenous inj ampicillin 1 gm q6h IV, inj gentamycin 160 mg in 100 ml NS od and inj flagyl 500 mg q8h and continued for 5 days. She didn’t develop any fever during her stay in the hospital. She was discharged on the 5th post op day in a stable condition.

Discussion

Faecal contamination during surgery has been described in the literature as part of bowel injury. Treatment for bowel injury lavage of the peritoneal cavity and drainage colostomy(4)(1)(2). Mere contamination with faecal matter without bowel injury has not been described yet in the literature to our best knowledge, after extensive search in the internet(5)(6)(2). What we learned from our experience is that a very conservative approach to this complication during surgery is acceptable. Though there was no major morbidity due to the faecal contamination, this complication could have been easily avoided had the thighs of the patient been abducted slightly to avoid close apposition while positioning the patient for surgery. A routine check should be done preoperatively to make sure the patient has passed stool before taking up for surgery.

References
