Clinics in Surgery

Case Report
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A Rare Case of Squamous Cell CA Arising from Drain Site Enterocutaneous Fistula- A Case Report

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Abstract

Malignant degeneration of long standing fistula is extremely rare and only one case has been reported so far in 2005. We herein report the 2nd case of longstanding entercutaneous fistula following left nephrectomy. The clinical pictures, radiological features are highlighted. Excision of the fistulous tract was done, which turned out to be squamous cell carcinoma. This case brings to notice that due to its insidious course, longstanding colocutaneous fistula should be carefully examined for tumor development.

Introduction and Aims

An Enterocutaneous Fistula (ECF) is an abnormal connection that develops between the intestinal tract or stomach and the skin. As a result, contents of the stomach or intestines leak through to the skin. 85% to 95% of Enterocutaneous Fistula arises in post operative period [1]. Other causes include infection, perforated peptic ulcer, inflammatory bowel disease, Crohn's disease or ulcerative colitis. In these patients, mortality remains high between 3% to 22% [2]. In 2005 only one case of long standing colocutaneous fistula which revealed squamous cell carcinoma [3]. Complications include a significant mortality (5% to 20%) [4], attributable to associated sepsis, nutritional abnormalities, and electrolyte imbalances. However malignant degeneration of Enterocutaneous Fistula has been rarely reported so far. This is a case report of second case of Enterocutaneous Fistula turning into malignancy.

Case Presentation

A 29 year old gentle man, manual labour, with no comorbidities. Status post left nephrectomy for unknown indication at the age of 10 years, presented with long standing intermittent pus (since 8 years) and feculant discharge from left flank at the drain site scar (Figure 1) patient was conscious, oriented, systemic examination was normal, Vitals were stable, per abdomen was soft, Bowel Sounds was present. Midline laparotomy scar local examination revealed Fistulous tract opening was present in the left flank 4 cm from the posterior iliac spine, surrounding hyperpigmentation and scarring, healthy granulation tissue, inner aspect of fistula with pus discharge was present (Figure 2). A case of enterocutaneous fistula for evaluation was the initial diagnosis at evaluation.

On investigation, blood investigations were within normal limits. USG revealed ill defined mural thickening of descending colon, Enterocutaneous fistula of the left lumbar region, minimal

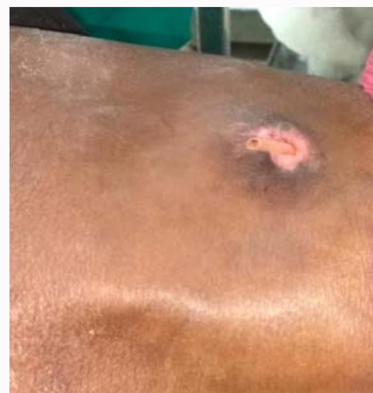

Figure 1: Fistulous track with pus discharge.

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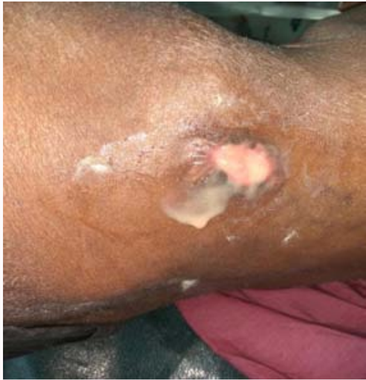

Figure 2: Fistulous track with intraadominal extension.

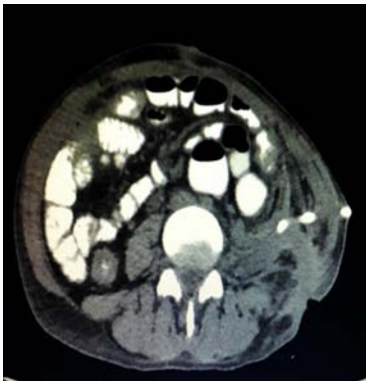

Figure 3: CECT Scan Showing Fistulous Tract.

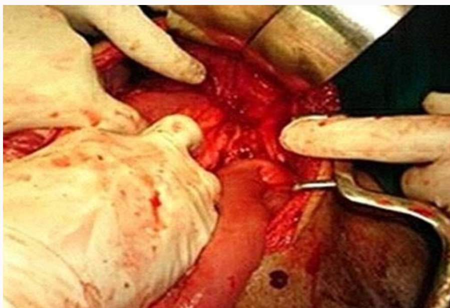

Figure 4: Fistulous Tract.

peritoneal collection. Figure 3 shows CECT findings. Pus culture and sensitivity from the discharge showed vancomycin resistant enterococcus. Procedure which was done was excision of fistulous tract, with primary closure of descending colon site of fistula (Figure 4). Postoperative period remained uneventful, 2 weeks later colonoscopy was done and showed a normal study. Histopathology revealed a moderately differentiated squamous cell carcinoma (Figure 5). Patient remained asymptomatic and was in regular follow-up and observation till 6 months post surgery. Then he developed sepsis and died.

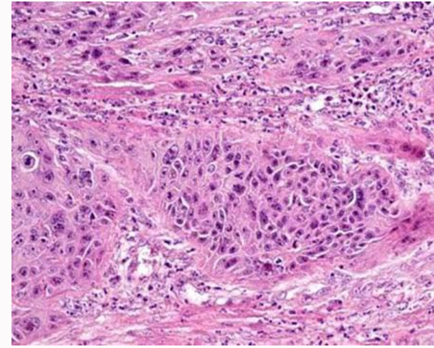

Figure 5: Histopathology.

Discussion

It is well known that surgery is still the most common cause of enterocutaneous fistula. The causes of persistent enterocutaneous fistula include foreign body, radiation, infection, inflammation, epithelization, neoplasm and distal obstruction. The development of squamous cell carcinoma as the result of chronic irritation and infection due to unhealed wounds could be considered. Because of its insidious course, the long-standing colocutaneous fistula should be examined carefully for tumour development, and surgery is inevitable for long-term unhealed fistula. Simple suture of the fistula not to be done.

Conclusion

Most uncomplicated enterocutaneous fistula will close spontaneously when properly managed. Surgery is usually not an immediate priority except to deal with complications. However, when surgical intervention is required to deal with the fistula, resection and anastomosis or bypass procedures are the preferred surgical procedures. Simple suture of the fistula is not recommended which lead to grave complications as in this case report.

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