Appendicular Fistula.

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Mr. P.B. male, aged 40 years was admitted to Bir Hospital on March 2023 with a discharging sinus over the right groin. This had been present over the last three years. During this time he had recurrent attacks of pain in the right side of the abdomen. About 3 years back he had an acute attack of pain in the right iliac fossa. He was very ill. During the course of his illness, he developed a swelling in the right side of the abdomen: it ulcerated and burst to discharge a large quantity of pus. The wound has been discharging pus intermittently since then and refuses to close. He passed twelve roundworms through this sinus. There is no faecal material in the discharge. He gets recurrent attacks of pain in the right iliac fossa. This remains for a day or two. The quantity of pus increases during the attack of pain. The discharge becomes more thicker during the attack. He had about four such attacks during the last three years.

On Examination. Young man, slightly anaemic and undernourished. There was a small sinus in the right groin below the right inguinal ligament about half an inch medial to the anterior superior iliac spine. The sinus was discharging frank pus. A probe passed through the external opening, passed to the depth of six inches. The right iliac fossa was tender on deep palpation. No lump was palpable. The rectal examination gave no definite clue.

Investigations. Blood. Hb.—72%, E.S.R.—12mm/1st. hour (Wintrobe). Urine. Normal. Stool.—both fertilised and non-fertilised ova of ascaris lumbricoides were present. Plain X-Ray of abdomen—revealed gas filled coils of intestine. Fistulography—The dye (IODOTOL) was injected through a catheter passed into the sinus tract through the external opening. The dye outlined a long tortuous tract, caecum, ascending and transverse colon. The dye did not pass into the ileum. Barium meal follow through examination showed normal ileocaecal junction and did not reveal the fistulous tract.

Diagnosis of a colonic fistula was made.

Treatment. The patient received nutritious diet, a course of liver extract and iron. He was given an ounce of piperazine citrate daily for four nights. The large gut was washed daily at bedtime with warm water. He also received a course of Enterostrep capsules for three days before operation. The operation was done under general anaesthesia with muscle relaxant. The abdomen was opened through right paramedian incision with a T extension towards the right iliac crest. There were a few roundworms in the small intestine. The methylene blue injected into the tract was seen in the colon. A probe introduced through the external opening passed through the appendix and its tip was lying in the caecum. The appendix was chronically inflamed and was adherent to the surrounding structures. The adhesions were separated and the appendix was mobilised with the probe in situ. There was an opening at the tip of the appendix. The appendix was removed from its base. The stump was invaginated. The sinus tract was excised and a corrugated rubber sheet drain was put in the right iliac fossa through the sinus tract. Penicillin and streptomycin were instilled into the peritoneal cavity. The abdomen was closed in layers. During the post-operative period the fluid and electrolyte balance was maintained. The oral feeds were allowed from the third day onwards. The patient received a course of penicillin and streptomycin for six days. The drainage tube was removed on the third post-operative day: the tract was clean. On the 5th. post-operative day, six roundworms escaped through the tract left for the drainage tube. The patient again received an ounce of piperazine citrate for another three days. He did not pass any roundworms. Subsequently the tract closed and it was dry on the 9th. day. The stitches were removed on the 10th. day and he was discharged cured on the 12th. post-operative day.

Histological examination of the appendix confirmed it to be chronically inflamed. Re-examination on the 20th. of Paush, 2023, (after a month of operation) showed that the scar to be fine and the sinus completely healed up.

DISCUSSION

Untreated cases of appendicitis may form appendicular abscess. This abscess may burst to discharge the pus with appendicular debris. The

condition usually subsides after the evacuation of pus: but the patient may get another acute exacerbation of appendicitis after sometime. In this case, the sinus did not close and formed an appendicular fistula. Because there was no obstruction to the bowel beyond ileo caecal junction faecal matter did not pass out through the fistula. The discharge consisted of secretions from the chronically inflamed appendicular mucosa. That the lumen of the appendix was patent is proved by the fact that the roundworms escaped through the fistulous tract, the radiological confirmation of the colonic fistula (By *Fistulography*) and the passage of probe passed from the external opening through the appendix to the caecum. It seemed really strange that the fistula should have continued to discharge when the lumen of the appendix was patent. As a rule, if the normal passage is patent, the abnormal path closes. In fact our diagnosis of appendicular fistula was only confirmed at the operation table. The large gut was sterilised and we were prepared for hemicolectomy. Simply closure of the colonic fistula may be very difficult technically. Once the probe passed through the appendix, simple appendicectomy and the excision of the fistulous tract was decided. As a routine 2/0 catgut was used to ligate the appendicular stump and to invaginate it. The roundworms digested the catgut and escaped through the tract left for the drainage tube on the 5th post-operative day. Later on, as the large gut was patent, the opening sealed up and the fistulous tract was closed. The patient was also free from pain in the right iliac fossa. The escape of the roundworms during the post-operative period could have been prevented by using silk thread to ligate and to invaginate stump; but we did not want to use unabsorbable material at a place where infection was present from before.

SUMMARY

A case of appendicular fistula has been described. The mode of onset of the fistula, the method of investigation and the line of treatment has been discussed.

References

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