Unusual presentation of more common disease/injury

Spontaneous enterocutaneous fistula due to femoral hernia

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Summary

Spontaneous enterocutaneous fistula is a rare entity. We encountered a case of spontaneous enterocutaneous fistula in the groin region due to femoral hernia. A 60-year-old man presented with spontaneous enterocutaneous fistula in the left groin region without signs of peritonitis. He was kept on conservative treatment, but on third postadmission day, he developed a swelling in his right groin, which became firm and irreducible with signs of intestinal obstruction. On exploratory laparotomy, bilateral femoral hernias were noted with formation of enterocutaneous fistula on the left side. Reduction and repair of hernia was performed. In view of the rarity of this complication, this case is being reported here.

BACKGROUND

Most of the enterocutaneous fistulae are postoperative.¹ Spontaneous enterocutaneous fistula is an uncommon clinical condition. The causes of spontaneous fistula are Crohn's disease, diverticulitis, appendicitis, neoplasm, radiation, intestinal tuberculosis, enteric fever and strangulated inguinal and femoral hernias.² Very few cases of femoral hernia presenting as enterocutaneous fistula have been reported.³ However, no case of bilateral femoral with unilateral enterocutaneous fistula has been reported. We encountered a case of bilateral obstructed femoral hernia with the formation of enterocutaneous fistula on one side. Being an extremely uncommon entity, it is being reported with a brief review of the relevant literature.

CASE PRESENTATION

A 60-year-old man presented to the department of general surgery with 1-month history of mild-grade fever, colicky abdominal pain, vomiting and abdominal distention. He was kept on conservative management at a district-level hospital, which gave him some relief. However, after a few days, he developed a swelling in his left groin region, along with recurrence of pain and fever, which got ruptured by the next day with discharge of faecal matter.

On examination, the vitals of the patient were stable. There was an enterocutaneous fistula in the left groin. As there were no features of obstruction, the patient was kept on conservative management. During the course of stay, the patient also developed a swelling in his right groin. The swelling was firm and irreducible (figure 1). A diagnosis of obstructed femoral hernia was made and the patient was prepared for emergency laparotomy.

TREATMENT

On exploration, bilateral femoral hernias were noted, with formation of faecal fistula on the left side.

After dilating the femoral ring, reduction of hernia, along with intraperitoneal repair was performed. Perforated bowel segment was resected, along with creation of double-barrel ileostomy. The left groin skin wound was debrided and left open for healing by secondary intention (figure 2).

OUTCOME AND FOLLOW-UP

The postoperative period was uneventful. After 8 months of follow-up, the patient is having no other complaint or recurrence.

DISCUSSION

Fistulae between the alimentary tract and skin may be classified as postoperative or spontaneous. Approximately three-quarters of fistulae occur following an operation, most commonly subsequent to procedures performed for malignancy, inflammatory bowel disease or adhesions.¹ Patient factors that increase the likelihood of developing a postoperative fistula include malnutrition, infection and emergency operations with concomitant anaemia, hypothermia and poor oxygen delivery.

Figure 1 Left side spontaneously ruptured femoral hernia. On right side, a double-barrel ileostomy is seen.

Figure 2 Right-side irreducible femoral hernia.

The remaining 25% of fistulae do not occur following a surgical procedure. These spontaneous fistulae often develop in patients with cancer or following radiation therapy. Fistulae occurring in the setting of malignancy or irradiation are unlikely to close without operative intervention. A second major group of patients with spontaneous fistulae are those with inflammatory conditions such as inflammatory bowel disease, diverticular disease, perforated ulcer disease or ischaemic bowel.² Of these, fistulae in patients with inflammatory bowel disease are most common; these fistulae often close following a prolonged period of parenteral nutrition, only to reopen when enteral nutrition resumes.⁴ Crohn's disease is the most common cause of spontaneous small bowel fistula.⁵ The majority of enterocutaneous fistulae arise from the small intestine. Around 70–90% of enterocutaneous fistulae occur in the postoperative period.^{6–7} Spontaneous small bowel fistulae arise from inflammatory bowel disease, cancer, peptic ulcer disease or pancreatitis.

Femoral hernia is the fifth commonest type of abdominal wall hernia, accounting for only 3.7% cases. It

accounts for less than 2% hernias in men, and just over 14% in women.⁸ Femoral hernia is notorious for strangulation, but enterocutaneous fistula formation is a rare entity. There have been occasional reports of enterocutaneous fistula following various types of hernia.^{3–9–1} However, the report described here has not been reported previously.

Learning points

- ▶ Femoral hernia is uncommon in male patients.
- ▶ Enterocutaneous fistula following obstructed femoral hernia may result from mismanagement.
- ▶ It is an extremely uncommon entity; hence, the treating surgeon must keep it as a differential diagnosis for better outcome.

Competing interests None.

Patient consent Obtained.

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Please cite this article as follows (you will need to access the article online to obtain the date of publication).

Kumar A, Pahwa HS, Pandey A, Kumar S. Spontaneous enterocutaneous fistula due to femoral hernia. *BMJ Case Reports* 2012;10:1136/bcr-2012-006939, Published XXX

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