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Case Report

Fallopian Tube Herniation through the Drain Site: A Rare Case Report

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Abstract

Intra-abdominal drains have been used since long to prevent intra-abdominal collection, and detect any anastomotic leaks. Their use is not without complications. We report a case of a 24-year-old female, who presented with fallopian tube herniation through the drain site that was kept during cesarean section. The drain was kept in view of hemolysis, elevated liver enzyme levels, and low platelet levels syndrome. On 5th post-operative day, the patient presented with this herniation, and she was managed appropriately. By presenting this case report, we aim to reduce such complications in future. Drains are used to drain body fluids in certain circumstances but do not prevent infection or promote wound healing. Drainage tubes are not a substitute to a good surgical technique.

Key words: Drain site, Fallopian tube, Herniation

INTRODUCTION

Drains inserted after surgery to drain accumulated fluid content sometimes become the focus of infection such as blood and pus. They do not promote wound healing or prevent infection. However, they are also associated with complications such as hemorrhage, infection, tissue damage, pain, blockage, and herniation of viscera. However, in current practice, their use is restricted by good surgical techniques and confidence of surgeons, except for in unavoidable in certain clinical situations.[1-3]

CASE REPORT

A 24-year-old, primi at 37 weeks gestational age was referred from nearby government headquarters as jaundice complicating pregnancy. She was admitted, evaluated, coagulation abnormalities corrected with blood products.

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The patient was stable while the cause of jaundice was still investigated for the next day she had fetal distress. An emergency lower segment cesarean section was performed to deliver an alive preterm female baby of birth weight 2 kg and good APGAR. Postoperatively her renal parameters were in the rising trend with adequate I/O, ultrasonography revealed B/L hydronephrosis, and she was diagnosed as nonoliguric renal failure on conservative management.

On the 4th post-operative day, drain that was placed on the left side was removed and small pinkish viscera protruded through the drain site. The size of it increased as the patient coughed and increased intra-abdominal pressure. The viscera were identified as fallopian tube and as time passed it became edematous.

The next day, relaparotomy and resection of the herniated fallopian tube was performed. The other side fallopian tube and ovary were normal. Thorough peritoneal wash given. The patient was started on higher antibiotics.

Despite all this, the patient developed one episode of generalized tonic-clonic seizure the next day and was febrile. She was intubated and investigated with a provisional diagnosis of metabolic seizures. Computed tomography brain revealed multiple infarcts and she was started on

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octreotide and antiedema measures. Her general condition improved and was extubated 2 days later (Figures 1-3).

DISCUSSION

The use of intra-abdominal drain dates back to Hippocrates era with the first drain being used for a case of empyema gallbladder. The only definitive indication for the use of pelvic drain, after surgery, is following tubo-ovarian abscess or presence of infection. Although it is advisable to leave a pelvic drain when there is evidence of clotting defect, a drain is not a replacement for achieving hemostasis. There are proponents and opponents, but the type of drain and its use is largely a matter of personal preference. Different types of drains are used in the peritoneal cavity including passive, closed suction, and stump.

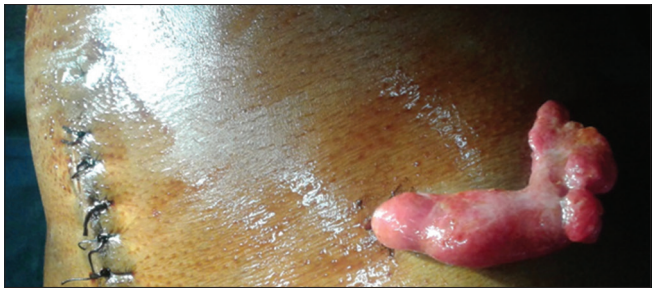

Figure 1: Hernated fallopian tube – Fimbrial end

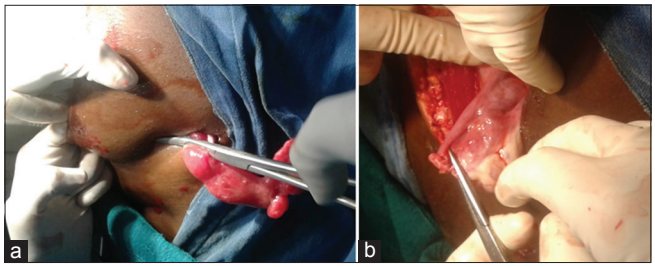

Figure 2: (a and b) Surgical correction of fallopian tube herniation

Figure 3: Resected end of fallopian tube

Studies regarding the use of prophylactic drains have come up with controversial results. However, it is associated with increased rate of infection, discomfort, and post-operative morbidity. It has been reported that herniation of viscera increases with increase in port size more than 10 mm. Factors which increase intra-abdominal pressure such as coughing, straining, prolonged surgery poor nutrition, infection, obesity, and steroid use may cause poor wound healing and herniation.

In our case, the patient had poor nutrition and respiratory infection that would have resulted in herniation of fallopian tube through the drain site.

As the laparotomy for the herniated fallopian tube was performed the next day, she had fever and developed infection. Hence, early repair would result in better outcome with low morbidity.

CONCLUSION

Drains are not a substitute for good surgical techniques. Surgical drains are associated with different complications and herniation of viscera is one among those. Herniation of fallopian tube is uncommon. Prevention of tubal prolapse can be achieved by suturing the adnexae high in the pelvis at abdominal hysterectomy and by the proper closure of the pelvic peritoneum. Correction of respiratory infections which increase the intra-abdominal pressure and predispose to herniation through drain site is very important.

REFERENCES

1. Mosley JG, Jantet G. Herniation at the site of an abdominal drain. Br J Clin Pract 1978;32:56-8.
2. Ozkan OV, Semerci E, Aslan E, Ozkan S, Dolapcioglu K, Besirov E. A right sliding indirect inguinal hernia containing paraovarian cyst, fallopian tube, and ovary: A case report. Arch Gynecol Obstet 2009;279:897-9.
3. Candiani GB, Candiani M. Posthysterectomy fallopian tube herniation: A report of two cases. J Reprod Med Obstet Gynecol 1996;41:915-20.

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