

Colocutaneous fistula after percutaneous drainage in a patient with diverticular disease

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We would like to draw readers attention to colocutaneous fistulas, notable rare in this letter. In this report, we present a patient with colonic diverticular disease Type III according to Hinchey classification mimicking subcutaneous abscess and despite effective antiinflammatory therapy and drainage resulting colocutaneous fistula. However, internal fistulas of diverticular diseases are well-defined in literature, colocutaneous fistulas well not documented after percutaneous drainage of a cutaneous abscess [1-3].

A 63-year-old man with a faecal fistula in the left lower anterior abdominal region was admitted to our Department of Surgery. The patient's chief complaint is abdominal pain and low-output fecal purulent discharge from a fistula tract (Figure 1). Three days before presentation, the patient was felt colicky pain in the lower left abdominal quadrant. After the pain persisted and, on the following day, it intensified and was accompanied by a recorded fever of 38 °C. He has not noted any changes in his bowel movements. The patient has not taken any medication for the abdominal pain.



Figure 1. The appearance of fistula orifice at left and at right macroscopic appearance of the resected inflamed colon segment with perforated diverticulitis.

His past medical history included diabetes mellitus, and no significant any disease. He had percutaneous drainage with the diagnosis of subcutaneous abscess 28 days ago in an Invaziv Radiology Section of a different hospital. CT showed peridiverticular abscess formation sprawling into the rectus abdominis muscle and subcutaneous planes.

With these imaging findings in hand, we considered a colocutaneous fistula triggered by percutaneous drainage of an abscess originated perforated diverticular disease. As a result, we performed laparotomy which revealed a mass that sigmoid colon herniation originating from an inflamed diverticulitis through the posterior rectus sheath in the left lower abdominal wall and cutaneous fistula formation. We reduced the mass containing inflamed colon segment, and performed segmenter colon resection with end-to-end colocolic anastomosis. We curetted fistula tract, and sutured the posterior fascia of the rectus muscle. The patient was discharged on the 7 th postoperative day of the surgery. At follow-up examination after three months the patient was in good condition. Histologic examination of the specimen showed no malignancy.

In our view, differential diagnosis is an important entity for abdominal skin abscess. We think that, surgical resection of fistulised segment is reserved for those Grade III diverticulitis. Drainage with imaging studies must be applied to prevent unwanted local and systemic complications.

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