An uncommon abdominal fistula: Colonic diverticular disease complicated with colocutaneous fistula

Cristian Mesina1, Theodor Viorel Dumitrescu1, Firmilian Calota1, Ciobanu Daniela2

1Department of Surgery, Emergency County Hospital of Craiova; University of Medicine and Pharmacy of Craiova, Craiova, Romania
2Department of Internal Medicine, Emergency County Hospital of Craiova; University of Medicine and Pharmacy of Craiova, Craiova, Romania

Dear Editor,

Colocutaneous fistulas are very rare, account for 1%-4% of the total number of fistulas complicating diverticular diseases, and may be caused by percutaneous drainage of diverticular abscesses without subsequent resection (1). They are more likely to occur in a patient who has undergone resection and primary anastomosis. In this letter, we report a case of a patient with a fistula connecting the sigmoid colon with left iliac fossa skin as a complication of sigmoid diverticulitis.

A 45-year-old male was admitted to our department for cutaneous fistula formation and seropurulent secretion in the fistulous opening. Initially, the patient with complicated colon diverticular disease had been admitted to another hospital 3 months previously with an abscess in the left iliac fossa, and its drainage was performed. Postoperative evolution was unfavorable with fistula formation in the scar (Figure 1). Physical examination indicated the presence of a postoperative scar with signs of inflammation and at the lower pole of the postoperative scar, a fistulous orifice with a diameter of 0.2-0.3 cm discharging the seropurulent fluid.

Fistulography of the left iliac fossa emphasized opacification of the sigmoid loop with inflammatory changes and incomplete lumen stenosis over a distance of approximately 10 cm.

Abdomen and pelvis computed tomography (CT) revealed infiltration with inflammatory aspect of subcutaneous fat in the anterior and left abdominal wall. At the lower pole of the postoperative scar, inflammatory process spread in the intrapelvic region without extending to the left iliac muscle, but with no cleavage plane toward the ileal loops. It also revealed the presence of fluid and air bubbles in the abdominal wall muscles (Figure 2).

During surgical intervention, we found inflammatory process in the left iliac fossa involving the side of the sigmoid colon, anterior abdominal wall, and greater omentum. Releasing the sigmoid loop was difficult. A fistulous orifice with a diameter of 0.4-0.5 cm, thickened wall, and irregular edges was identified. Sigmoidectomy with end-to-end colorectal anastomosis was performed as a one-step procedure.

Postoperative specimen consisted of a 25-cm sigmoid segment, which contained three perforated diverticula (when it

Figure 1. Physical examination revealed a fistulous orifice that discharged seropurulent fluid at the lower pole of the postoperative scar
The patient underwent treatment with iv cefotaxime+metronidazole for 7 days during hospitalization and with oral ciprofloxacin + metronidazole for another 5 days after being discharged. The postoperative course was favorable, and the patient was discharged after 7 days. During the 48-month follow-up, no recurrent diverticulitis was observed on colonoscopy and CT.

In conclusion, patients with a manifestation of subcutaneous abscess in the left iliac fossa or flank area with previous episodes of diverticulitis should be suspected of having diverticular sigmoid perforation and abdominal wall fistula formation.

**REFERENCES**