Caeco-vesical fistula – an unusual sequel of colonic tuberculosis

To the Editor: We would like to report on a rare case of caeco-vesical fistula complicating ileo-caecal tuberculosis, a condition that has not been described in the literature.

A 4-year-old boy, with a positive family history of tuberculosis, presented to hospital with a month’s history of dysuria and faecula. He was pyrexial, with a tender right suprapubic mass and leucocytosis. The chest radiograph was normal; abdominal ultrasonography demonstrated the presence of a fistula with echogenic debris originating from within a bowel loop and extending into a thick-walled bladder (Fig. 1). Cystography and computed tomography (CT) failed to delineate the fistula.

At laparotomy caseating mesenteric lymph nodes and an inflammatory mass involving the terminal ileum, caecum and urinary bladder were found. A limited right hemicolecotomy and a wedge resection of the bladder were performed followed by primary ileo-colic anastomosis, and closure of the bladder defect. Section of the resected specimen confirmed a caeco-vesical fistula and histological analysis confirmed tuberculous colitis. The patient was commenced on antituberculosis treatment and he remains well 9 months after the operation.

Gastrointestinal tuberculosis may be found in any part of the gastrointestinal tract, but ileo-caecal involvement is most common, occurring in 70 - 90% of cases. The site of enteric origin is influenced by aetiology, the most common causes being diverticulitis, colorectal cancer and Crohn’s disease, in that order. Most tuberculous perforations and internal fistulas have been reported in the ileum and their occurrence in the colon is very rare. A fistula between the caecum and the urinary bladder due to tuberculosis has not been described in the literature.

Entero-vesical fistulas are a diagnostic and therapeutic challenge to surgeons and they may appear as either a genitourinary or an enteric problem. The most common presenting complaints are pneumaturia and faecula and the other less common clinical features include abdominal pain, gastrointestinal symptoms and haematuria. Diagnosis by ultrasound is unusual and the demonstration of flow of enteric content into the bladder through the fistula in the present case was striking. Although CT is reported to have a diagnostic accuracy rate of 90 - 100%, it was not helpful in this case. Cystography failed to demonstrate the fistula, possibly because of the difficulty in generating enough intravesical pressure to oppose the natural downstream flow of the fistula contents from the caecum to the bladder.

In general the response of abdominal tuberculosis to standard antituberculosis therapy is rapid, with signs and symptoms resolving within a few weeks or even a few days. The therapeutic goals in the management of tuberculous fistula include resection of the involved bowel, establishing enteric continuity and repairing the bladder defect as well as instituting antituberculosis therapy. Spontaneous resolution of a tuberculous fistula has not been described in the literature, and it is not clear whether the fistula in the present case would have healed had the diagnosis been made pre-operatively and had antituberculosis therapy been commenced.

This is an unusual case of a tuberculosis internal fistula between the caecum and the bladder, which highlights the protean manifestations of tuberculosis. In the era of HIV and AIDS where immunosuppression abounds, a diagnosis of tuberculosis should be considered in patients presenting with a fistula irrespective of the site. Treatment principles involve surgical correction of the fistula and administration of antituberculosis therapy.

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During the past decade the discipline of hepatology has burgeoned worldwide, and its importance and relevance have increased logarithmically with the availability of liver transplantation and the widespread pandemic of hepatitis B and more recently hepatitis C. Hepatology is closely related to numerous allied fields of medicine including surgery, radiology, oncology, pathology (histological and biochemical), infectious diseases, toxicology, immunology, tropical and occupational medicine, and systemic diseases.

This book is authoritative and comprehensive with a crisp and clear style and provides an updated and systematic overview of the field. The attractive layout and organisation of the content make the book a delight to browse through and a pleasure to read. The text is abundantly supplemented by 380 colour illustrations showing microscopic histological images, laparoscopic and endoscopic views and the gamut of radiological liver images. Included are 276 helpful colour-coded tables (blue for classifications, causes, indications; red for pathological findings, complications; yellow for methods and tests, etc.), which provide a synopsis of the data. Each of the 40 chapters is followed by an extensive bibliography (over 7 300 up-to-date references in total) giving the reader access to minute detail and depth on specific topics. The medical and surgical therapeutic options and recommendations presented in individual chapters are systematically summarised in the final chapter.

In summary, this magisterial tome provides an excellent and authoritative account of hepatology, ranging from basic science, clinical features and investigations through to definitive treatment. Which audience will best be served by this book? It will be used by gastroenterologists, liver specialists, surgeons and basic scientists as their regular reference. In addition, it will be a welcome addition to library shelves as a superb resource and teaching manual for undergraduate and postgraduate students and a reference book for clinicians to dip into when confronted by unusual liver-related problems.

J. E. J. Krige


The formation last year of a pelvic floor interest group (the South African Urogynaecological Society) emphasises the gradual change in approach to pelvic floor problems from the traditional ‘vertical’ division (urologist in front, gynaecologist in the middle, and proctologist taking up the rear) to a ‘horizontal’, interdisciplinary approach that incorporates all three disciplines and more in a holistic approach. This fine production from Springer will form an essential part of the library of any group involved in these areas.

There are over 60 authors, half of whom are from Germany and Austria, and the remainder include most of the great names worldwide. At times the style is a little laboured (uneven translation?), but the layout is clear and accessible, and the references up to date – a mammoth task when co-ordinating so many authors.

Basic science and pathology are covered thoroughly, and the technical aspects of imaging (essential in the decrypting of these complex symptoms) are lucidly described. I was intrigued by the suggestion that dynamic magnetic resonance imaging
required revisionary surgery. The 2-year success rate is
the devices had to be removed, and nearly half the remainder
sphineter; in one multicentre study, more than one-third of
from Maastricht on dynamic graciloplasty, Lehur (Nantes)
the founding fathers of each of the approaches – Baeten
incontinence have been written by a galaxy of luminaries,
The chapters on the more invasive procedures for faecal
on one's interpretation.
Because of this, it is essential that the surgeon perform the
without [endoanal ultrasound]. Unfortunately, the accuracy
test, viz. a dynamic challenge using a bolus. They are also
explain how the results of any 'physiological' tests
manometry, etc.) alter the management of a case.
The chapter on medical treatment of urinary incontinence
is outstanding, as is the one on behavioural therapy. I was
interested to learn of the poor long-term results following
silicone injections (Macroplastique) – at best, only 30% at 3
years. In consequence, the method seems to have been largely
abandoned in Europe.
Urologists should be reassured that slings and other surgical
approaches to the various forms of urinary incontinence are
exhaustively covered, but this reviewer's lack of experience in
the field precludes any detailed analysis of the material.
Medical and behavioural therapy for faecal incontinence is
thoroughly covered. Those who practise biofeedback may be
interested to learn that at the University of North Carolina,
biofeedback performed by a nurse under physician supervision
is remunerated by the funders at US$194 per session (i.e.
more than R1 000), using the CPT code 90911. It is also
their opinion that physiological testing guides the style of
biofeedback (e.g. strength training, or sensory training).
Moving on to surgical therapy, the authors are most
enthusiastic about the inflatable urinary sphincter, arguing that
it is 'currently the only method to treat urinary incontinence
in a physiological way'. Clearly the problems with the device
that dog its use in the anus arise much less in the urinary
tract.
No proctologist would argue with the assertion that '... surgery
for faecal incontinence should not be considered without [endoanal ultrasound]. Unfortunately, the accuracy
is investigator-dependent, the learning curve being rather flat.'
Because of this, it is essential that the surgeon perform the
investigation, because there is no other way to get feedback
on one's interpretation.
The chapters on the more invasive procedures for faecal
incontinence have been written by a galaxy of luminaries,
the founding fathers of each of the approaches – Baeten
from Maastricht on dynamic graciloplasty, Lehur (Nantes)
on the inflatable sphincter, and Matzel (Erlangen) on sacral
neuromodulation. Each chapter is balanced, thorough and up
to date. The most contentious method is the artificial bowel
sphincter; in one multicentre study, more than one-third of
the devices had to be removed, and nearly half the remainder
required revisionary surgery. The 2-year success rate is
approximately 50%, after which the results seem to remain
stable. Results with graciloplasty are fair, although long-term
outcomes are less clear, and the benefit of neuromodulation is
maintained well beyond 5 years. Review of long-term results
is made difficult by inherent design flaws in most studies,
which makes specific advice difficult. It is known that the
older procedures (overlapping sphincteroplasty; post-anal
repair) slowly (but steadily) fail.
Most South African (and UK) stomatherapists encourage
the use of appliances for a colostomy, while American practice
has long favoured irrigation. The authors of the chapter on
stomas suggest that quality of life is better with irrigation.
It may well be worth considering conversion to irrigation in a
cash-starved situation as prevails in most of Africa, since
daily costs are dramatically reduced, as is dependence on
suppliers.
The book concludes with useful chapters on the prevention
of urinary and faecal incontinence after urological and
proctological operations, and particularly after pregnancy and
vaginal deliveries, arguably the major causes of incontinence
overall.
This is a meticulous and valuable book, a source of
information over a wide range of fields with a balanced review
of the place of each intervention in the treatment of these
common and disabling conditions.

G. J. Oettle

Minimally invasive cancer management. Ed. by F. L.

Many books on laparoscopic surgery have been published
since the advent of modern video endoscopy in the 1990s, but
few have specifically addressed its role in the field of oncology.
This multi-author book begins with a chapter on important
general principles pertaining to minimal access surgery,
including indications, cancer biology, local abdominal wall
recurrence and various technical aspects of oncological
operations. This is followed by chapters describing in detail
the most important abdominal, thoracic and retroperitoneal
operations, complemented by excellent illustrations. The last
chapter in the book covers topics on minimal access cancer
management in children and sentinel lymph node biopsy
in the treatment of cancer. Over and above the technical
aspects of oncological surgery, several chapters also provide
supporting data of staging and results of these treatment
modalities.

While this book is targeted mainly at surgeons who perform
advanced laparoscopic operations and those who work in the
field of oncology, it would also be of interest to those who
have a general interest in laparoscopic surgery.

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