Iatrogenic Ureterocolic Fistula Following Laparoscopic Oophorectomy

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A 56 year old lady presented with gradual onset left flank pain, rigours and diarrhoea. Her past history was remarkable for an uneventful, elective bilateral laparoscopic oophorectomy one month earlier under the Gynaecology service. She had previously had breast cancer and was BRCA2 positive. On examination she was pyrexial and tender in her left flank. Computerised tomography revealed moderate left sided hydronephrosis, extensive air within her left renal pelvis and a distal left ureterocolic fistula (**Figures 1-3**). She was initially managed with antimicrobial therapy and stenting but eventually required a ureteric reimplantation.

Ureterocolic fistulae are rare and may occur as a result of iatrogenic injury[1]. Diverticular disease causing spontaneous ureterocolic fistulae has been reported[1,2] but the majority of cases occur due to impacted ureteric calculi.

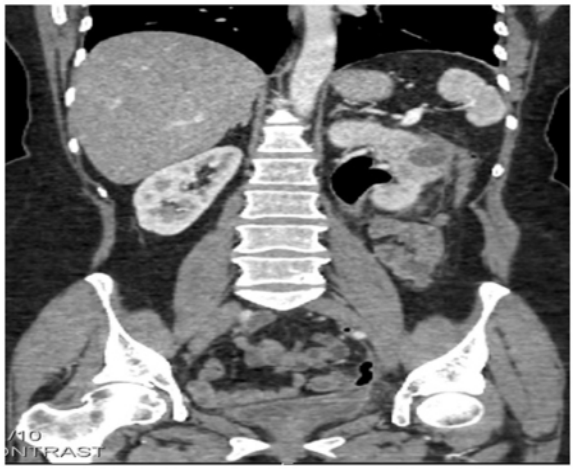

Figure 1. Computerised Tomography of the abdomen demonstrating gas in the left renal pelvis with a simple renal cyst and a normal contralateral kidney.

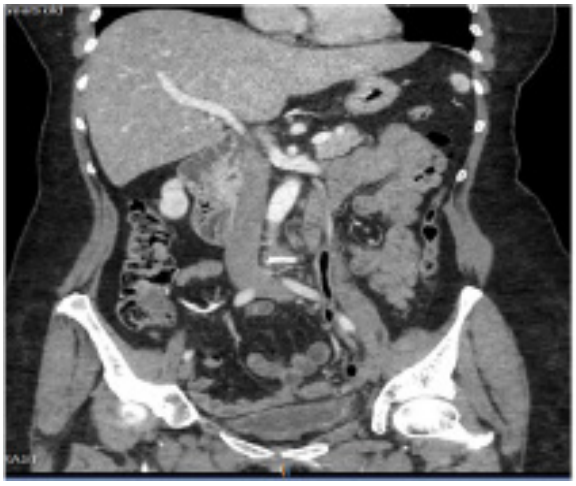

Figure 2. Computerised Tomography of the Abdomen demonstrating air in the mid and distal left ureter consistent with a ureterocolic fistula.

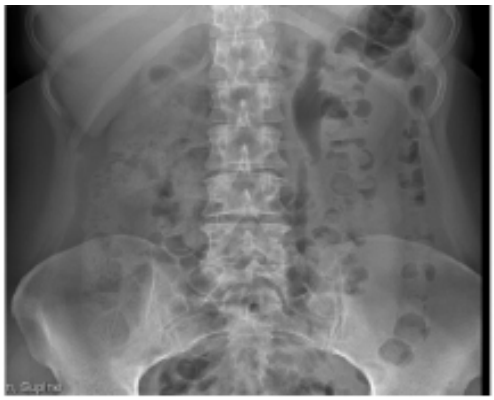

Figure 3. Plain X ray of abdomen demonstrating faecal loading and air in the left ureter extending up into the collecting system.

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Predisposing factors include inflammation, radiation, surgical trauma and neoplastic processes. Diagnosis is made via abdominal imaging[3] or intraoperative retrograde studies[1]. Management is usually surgical with either nephroureterectomy in cases of a poorly functioning kidney or segmental resection, ileostomy and stenting in selected cases. Conservative management has been described[3]. As the incidence of elective oophorectomy for cancer prevention increases it is likely that this form of ureteric injury will become more prevalent.

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