International Journal of Current Advanced Research
ISSN: O: 2319-6475, ISSN: P: 2319-6505, Impact Factor: 6.614
Available Online at www.journalijcar.org
Volume 7; Issue 11(C); November 2018; Page No. 16304-16305
DOI: http://dx.doi.org/10.24327/ijcar.2018.16305.3008

Case Report

PLEUROCUTANEOUS FISTULA COMPLICATING MULTI LOCULATED PYOPNEUMOTHORAX - POST LAPAROTOMY FOR SUBACUTE INTESTINAL OBSTRUCTION

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A R T I C L E I N F O

Article History:
Received 6th August, 2018
Received in revised form 15th September, 2018
Accepted 12th October, 2018
Published online 28th November, 2018

Key words:
Pleurocutaneous fistula, pyopneumothorax, Tube thoracostomy

A B S T R A C T

Introduction: Tube thoracostomy is one of the most commonly performed procedure in the thoracic region. It is an invasive procedure and many complications have been reported for this commonly done procedure, which can be due to either technical or infective etiology. We report a case of pleurocutaneous fistula which developed as a complication of tube thoracostomy put for as a complication of an abdominal surgery. Pleurocutaneous fistula is one of the rare complication reported post tube thoracostomy.

INTRODUCTION

Case Report

A 25 years old male, known case of congenital Diaphragmatic Hernia operated at 6months of age now presented with the complaint of abdominal pain for one month to the surgery outpatient Department. Patient was evaluated and diagnosed to have sub cute intestinal obstruction and was taken for laparotomy. Many adhesions were found in the intestine and the peritoneum and were released during the surgery.

Image showing pleurocutaneousfistula

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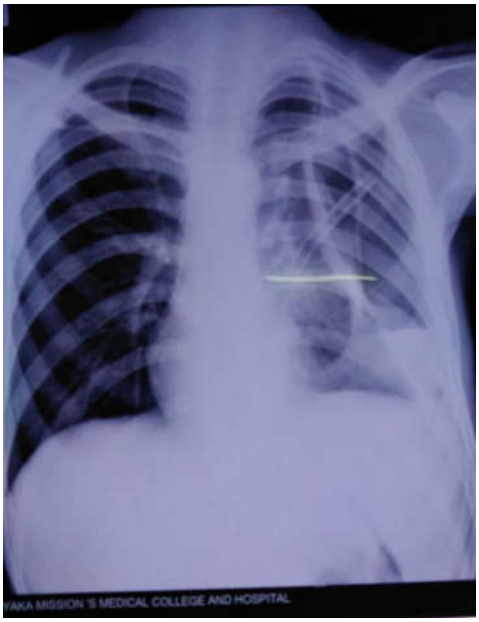

Chest x-ray showing loculations and ICD insitu in the posterior loculation

Pulmonology opinion was sought on the third post operative day since patient developed dyspneoa preceded with history of left sided chest pain.

Cardiologist opinion obtained was nil significant. Bed side chest x ray and ultrasound chest showed unilateral minimal pleural effusion. Reactive pleural effusion post abdominal surgery was the diagnosis made and planned for observation. Since patient had high grade fever, cough with increasing

dyspnea on then next day, ultrasound chest and computed tomography chest done showed consolidation with moderate pyopneumothorax with multi loculations. Intercostal drainage was put and pleural fluid sent for culture and sensitivity showed E.coli growth. Even though patient showed improvement with decrease in intercostal drain and resolution of consolidation after the appropriate antibiotics over a period of two weeks, there was discharge at the ICD site and residual pleural thickening in the chest xray. Gradually the ICD site healed as a pleurocutaneous fistula which was confirmed with chest ultrasound. cardiothoracic surgeon opinion has been obtained for thoracotomy and for decortication of the thickened pleura.

DISCUSSION

Pleurocutaneous fistula is defined as a pathologic communication between the pleural space and the subcutaneous tissues. Pleurocutaneous fistula secondary to tube thoracostomy has been reported in few studies[2]. Necrotising fasciitis at the intercostal drainage site is defined as one of the cause for pleurocutaneous fistula and out of many organisms commonly reported to cause this, E.coli is one among them[3]. Since in our patient E.Coli is reported as the bacteria in the pleural fluid it might have caused this complication. Even prompt treatment with appropriate antibiotics could not prevent the development of pleurocutaneous fistula., leading to further management

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How to cite this article:

Vanitha Gnanasoundran and Dhandayuthapani (2018) 'Pleurocutaneous Fistula Complicating Multi Loculated Pyopneumothorax -Post Laparotomy For Subacute Intestinal Obstruction', *International Journal of Current Advanced Research,* 07(11), pp. 16304-16305. DOI: http://dx.doi.org/10.24327/ijcar.2018.16305.3008

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