INTRODUCTION

Intra-abdominal drains are placed in the peritoneal cavity to drain fluid, both therapeutically and prophylactically. The presence of intra-abdominal drain is not without complications such as damage to viscera, blockage, hemorrhage, and pain.

Here, we present a rare case of left sided fallopian tube prolapse from the intra-abdominal drain site which was detected early and was reduced under local anesthesia without the need for salpingectomy.

CASE REPORT

A 27-year female, G1P0A0, was admitted in the gynaecology ward with previous pregnancy and underwent elective caesarean section for breech presentation. The procedure was uneventful except a small ooze from the operation site. No. 24 F Foley’s catheter was used as abdominal drain from the left lower abdomen to drain intra-abdominal collection. She developed postoperative pneumonia and was being managed in the medical ICU. Abdominal drain was minimal and removed on the second postoperative day.

On the fifth postoperative day, she noticed something coming out of her left sided drain site. On examination, there was blind ended edematous tube like structure with fimbriated end coming out of the drain hole site which was diagnosed clinically as prolapsed left sided fallopian tube (Figure 1). She was immediately shifted to the operation theatre, on table pre-anesthesia evaluation was done by anesthesia team and patient was declared high risk case for general anesthesia because of pneumonia. As the patient had short history of drain site fallopian tube prolapse, and the fallopian tube has not become gangrenous, a decision to reduce the tube under local anesthesia by enlarging the same wound was made. Local infiltration with 01% lidocain was done and the fallopian tube was reduced inside the peritoneal cavity. Patient was closely followed in the ICU, where she was being managed for pneumonia. She underwent smooth recovery and was discharged after recovery from pneumonia.

DISCUSSION

Hippocrates first used abdominal drain in a case of empyema gallbladder. The use of intra-peritoneal drain, after surgery for different indications, is under debate since long-time. There are proponents and opponents but the type of drain and its use is largely a matter of personal preference. Different types of drains are used in the peritoneal cavity including passive, closed suction, and sump. Traditionally Foley’s catheter is also being used as intra-peritoneal drain, especially in our part of the subcontinent. Nelaton drains are hard and less pliable and thought to cause pain due to irritation, especially if used in the sub-hepatic space. Foley's...
catheter is soft, radially available, and is commonly used to drain the peritoneal cavity.

The use of abdominal drain is not without risk. Various types of complications resulting from the use of abdominal drain starting from its insertion to removal has been described in the literature but our main focus in this report is herniation of viscera from the drain site. Different viscera including appendix, small intestine, ovary, gallbladder, and right sided fallopian tube prolapse have been described but the authors could not search any case of left sided fallopian tube prolapse from the drain site in the English literature. Sharma et al. described a case of fallopian tube herniation from right sided surgical drain which resulted in laparotomy and salpingectomy. Chatman described a case of tubal herniation and incarceration from laparoscopic port site. Wang reported another case of fallopian tube herniation from left sided laparoscopic trocar site resulting in torsion and necrosis.

This case was rare in the sense that it was detected early and as the patient was not fit for general anesthesia and the fallopian tube has not yet necrosed, it was reduced under local anesthesia by enlarging the same drain site wound with uneventful postoperative recovery.

The authors conclude that use of drains should be judicious, and small caliber drains should be used obliquely when required. Moreover, attention should be given to reduce the predisposing factors that raise intra-abdominal pressure.

REFERENCES