

CASE REPORT



Received: 28.12.2021

Accepted: 29.01.2022

Published: 08.04.2022

Citation: Monika R, Geetha HH, Mounika K, Sachdeva P. (2022). A Low Lying Rectovaginal Fistula: A Case Report. International Journal of Preclinical & Clinical Research. 3(1): 28-30. https://doi.org/10.51131/IJPCCR/v3i1.21_35

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Funding: None

Competing Interests: None

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Published By Basaveshwara Medical College & Hospital, Chitradurga, Karnataka

ISSN

Print: XXXX-XXXX

Electronic: 2583-0104

A Low Lying Rectovaginal Fistula: A Case Report

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Abstract

Rectovaginal fistulas (RVFs) are abnormal communications between the anus or rectum and the vagina and can present a challenge for both the patient and the surgeon. This condition can have extensive morbidity related to a negative impact on the patient's social, sexual, and overall quality of life and can be extremely disabling and associated with significant distress in affected women. Additionally, the morbidity and success of a repair is directly dependent on both the cause and the complexity of the fistula.

Keywords: Rectovaginal fistula; Obstetric trauma; Forceps; Colostomy

Introduction

Many small low rectovaginal fistulas represent incompletely healed (third degree) perineal lacerations that is involving the sphincters. Common causes are obstetric trauma coital injury, malignancies and IBD, Chron's disease. Obstetric injury is the most common cause of RVF.

Simple rectovaginal fistulas consist of small, low fistulas secondary to infection or trauma, but complex if large (>2.5 cm), high or caused by inflammatory bowel disease. Patients may present with stool per vagina resulting in frank incontinence, or gas or drainage per vagina.

Approximately 2% of all vaginal deliveries are associated with third- and fourth-degree perineal tears with 3% of these patients subsequently developing an RVF accounting for 0.1% to 0.5% of all vaginal deliveries.⁽¹⁾

Prolonged labour resulting in compression of the rectovaginal septum by the infant's head can lead to necrosis of the rectovaginal septum and cause an RVF that presents in a more delayed fashion

Case details

A 22-year-old P1L1 came with complaints of passage of stools per vagina for 5 days. She underwent forceps assisted FTVD 15 days back at the periphery hospital after having a prolonged labour, and she did not pass stools for next 7 days and presented with above complaints.

On admission vitals stable. Under IV sedation patient was examined on per speculum examination a rent of size 2*2cm at the level of introitus communicating with the rectum noted.

Per rectal examination complete loss of sphincter tone and tear in the anterior rectal wall noted.

She underwent fecal diversion through transverse loop colostomy. After 15 days of colostomy under SA, RVF repair with levatoroplasty with cross sphincteroplasty was done. From post op day 3 kiegel's excercise advised. After 6 to 8 weeks MRI contrast fistulogram was advised.

Reversal of colostomy done after 3 months.



Fig 1. Rent of size 2*2 cm at the level of introitus

Discussion

Third and fourth degree lacerations are considered as severe lacerations. Risk factors associated with this condition specifically vacuum or forceps assisted vaginal delivery. Most women with persistent symptomatic disease will not heal without surgical intervention. In addition, rectovaginal fistula from obstetric trauma is usually associated with coexistent occult sphincter injury.

Operative procedure include transvaginal, trans anal, abdominal and tissue transposition procedures. The endorectal advancement flap is popular among colorectal surgeons. Usually the patient is placed in the prone Jack-knife position under a general anaesthetic. The general principle is the excision and closure of the rectal portion of the fistula and coverage with a vascularized full-thickness rectal flap over a reapproximated rectovaginal septum on the high pressure side of the fistula. A randomized trial of 55 patients with non-recurrent complex cryptoglandular fistulas comparing fistulotomy combined with immediate sphincter reconstitution



Fig 2. Rent communicating with rectum causing RVF



Fig 3. Transverse loop colostomy

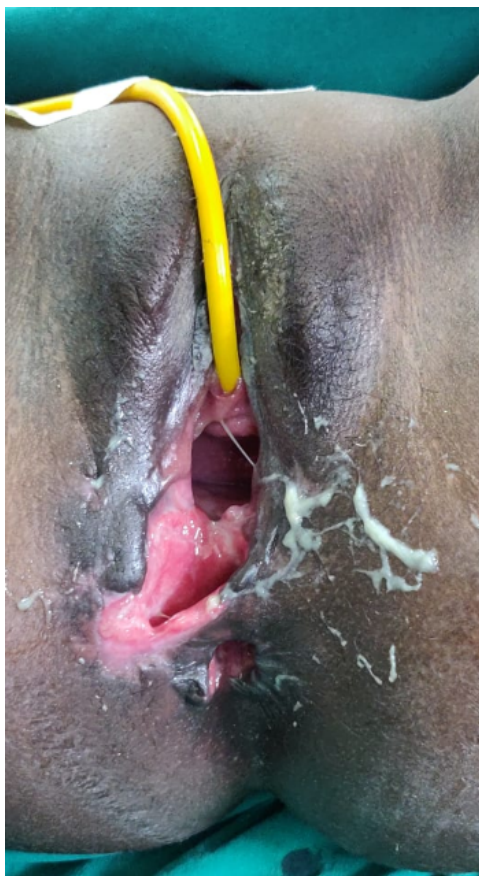


Fig 4. Pre op before repair



Fig 5. Post repair

and advancement flap repair had similar healing and functional outcomes

Postpartum care: The literature contains little information on patient care after the repair of perineal lacerations. The use of sitz baths and an analgesic such as ibuprofen is suggested. After repair, several weeks of therapy with a stool softener is given to minimize the potential for repair breakdown from straining during defecation.

The need for simultaneous diversion of feces is an area that is under-researched. Colostomies have been traditionally used to reduce infectious morbidity by diverting stools away from the perineal repair. Loop sigmoid colostomies allow full diversion of feces away from the distal bowel limb and are rapidly constructed, and are easily closed without laparotomy. The medical literature contains only a few case reports and small series with reports of colostomies during repair of acute injuries, but the indications are elusive and its performance is not standard. There is also a marked difference in expert opinion, with 30% of coloproctologists but no obstetricians recommending diversion for third- or fourth-degree tears in a recent practice survey. Colostomies may impair healing by reducing collagen metabolism and altering mucosal defense in the defunctionalized rectum. They may also increase infectious morbidity by attenuating mucosal integrity and promoting microbe translocation. And although our patient did not develop complications, 20-25% of patients experience additional morbidity at colostomy closure. We firmly believe that the severe anatomic disruption patient warranted diversion to protect the repair. Deciding on colostomy creation for fourth-degree lacerations is difficult because there is little evidence upon which to base management decisions. This is an area that is still under-researched. Further study is warranted and therapeutic decisions should be individualized at this time.

Prevention of perineal trauma can be decreased by minimizing the use of operative vaginal delivery. A meta-analysis of eight randomized trials of vacuum extraction versus forceps delivery demonstrated that one sphincter tear would be prevented for every 18 women delivered with vacuum rather than forceps.

Conclusion

Although many surgical approaches to correct them have been attempted management of RVF repair still remains a challenge. Main aim of RVF repair is to preserve sphincter tone. Success of surgical correction depends on correct cause, classification, location and accessibility of the RVF and status of sphincter tone.

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