Acta Medica Alanya

CASE REPORT

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Acta Medica Alanya

2018;2(1):43-45

DOI: 10.30565/medalanya.381815

A Rectovaginal Fistula Treated by Ligation of Intersphincteric Fistula Tract Method

İntersfinkterik Fistül Trakt Ligasyonu Yöntemiyle Tedavi Edilen Rektovajinal Fistül

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ABSTRACT

Rectovaginal fistulas are epithelial-lined communications between the rectum and vagina. A number of surgical options are available for patients with rectovaginal fistulas. In this manuscript, a case having rectovaginal fistula and treated by ligation of intersphincteric fistula tract method was presented.

Twenty-seven years old woman had low settled rectovaginal fistula. We decided to operate like an anal fistula and we performed ligation of intersphincteric fistula tract method. The patient was followed postoperatively for 3 months and she had no complaint. As much as we know, this is a rare case in the literature who was performed ligation of intersphincteric fistula tract method.

Keywords: Rectovaginal fistula, ligation, anorectal fistula.

ÖZ

Rektovajinal fistüller rektum ile vajina arasındaki epitel ile kaplı bağlantılardır. Rektovajinal fistüllü hastalar için bir takım cerrahi seçenekler mevcuttur. Bu yazıda, rektovajinal fistülü bulunan ve intersfinkterik fistül trakt ligasyon yöntemi uygulanan bir vaka sunuldu.

Yirmi yedi yaşındaki kadın hastada düşük yerleşimli rektovajinal fistül mevcuttu. Hastayı anal fistül gibi opere etmeye karar verdik ve intersfinkterik fistül traktının ligasyonu yöntemini uyguladık. Postoperatif 3 ay takip edilen hastanın hiçbir şikayeti olmadı. Bildiğimiz kadarıyla literatürde intersfinkterik fistül traktının ligasyonu uygulanan az sayıda vaka mevcuttur.

Anahtar Kelimeler: Rektovajinal fistül, ligasyon, anorektal fistül.

Geliş Tarihi: 20.01.2018 / Kabul Tarihi: 02.02.2018 / Yayınlanma Tarihi

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Rectovaginal fistulas are epithelial-lined communications between the rectum and vagina. Although they are rela¬tively uncommon, accounting for approximately 5% of all anorectal fistulas, they may cause significant physical symptoms in addition to adversely affecting intimate rela-tionships and sexual function. The operative approach to such fistulas depends on a variety of factors, including the size, location, condition of the surrounding tissues, and association with concomitant disease, such as inflam¬matory bowel disease. The lack of a uniformly successful surgical repair is a source of great frustration to both patients and surgeons [1].

The objectives of treatment are to achieve fistula healing, prevent recurrences and maintain continence. The risk of incontinence associated with treatment ranges from 10% to 57%. The disease has an incidence of 8.6 per 100000 people and nearly 20000 to 25000 fistulas are treated annually in the United States [2]. A case with rectovaginal fistula treated by ligation of intersphincteric fistula tract method was presented. As much as we know, this is the rare case in the literature.

CASE REPORT

27 year old woman presented with passage of stool and air through vagina for 7 years. She didn't have any surgery and disease history but had a history of 2 gravity with midline episiotomy. The time elapsed from delivery was 7 years. Her physical examination revealed a low rectovaginal fistula. Orifices of fistula were seen on physical examination and tract is showed with guide instrument (Figure1: Rectovaginal fistula and guide instrument). Any other diagnostic process was not made. We decided to operate like an anal fistula. Her preoperative hematological,,biochemical and radiological examination were all normal. Preoparative bowel preparation was made only with rectal enema. Primarily, internal orifice of fistula tract was excised then fistula tract epitelium was curetted (Figure 2: Intersphincteric space). Tract of fistula was ligated by 3/0 monocryl suture two times in intersphincteric space, the external opening was cutted at distal part of ligation point, external opening was excised widely (Figure 3:Postoperative Appearance). The patient was followed for 3 months and no complaint was mentioned.

DISCUSSION

The most common cause of rectovaginal fistula is obstetric trauma. A prolonged second stage of travail with ischemic necrosis of the rectovaginal septum may contribute to development of a fistula. Other risk factors include a high forceps delivery, shoulder dystocia, midline episiotomy, and third or fourth-degree perineal laceration [3]. Although fistulas after prolonged travail are rare in developed countries, they are still a relatively frequent occurrence in undeveloped countries [4]. Our patient gave us only a midline episiotomy history.

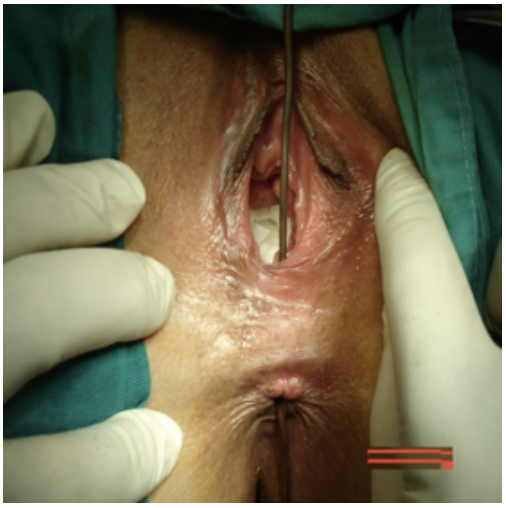

Figure1: Rectovaginal fistula and guide instrument

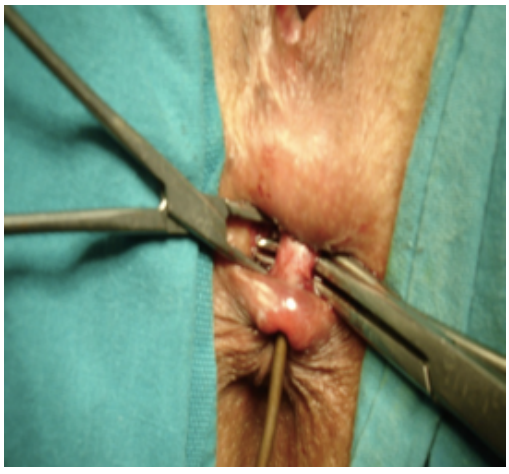

Figure 2: Intersphincteric space

The main presenting complaints of women with a rectovaginal fistula are passage of stool and air through vagina, foul-smelling vaginal discharge with recurrent vaginitis or urinary tract infections may be the presenting complaints [1]. Our patient had all these complaints.

Although many women seek medical attention immediately, it is not uncommon for whose have more

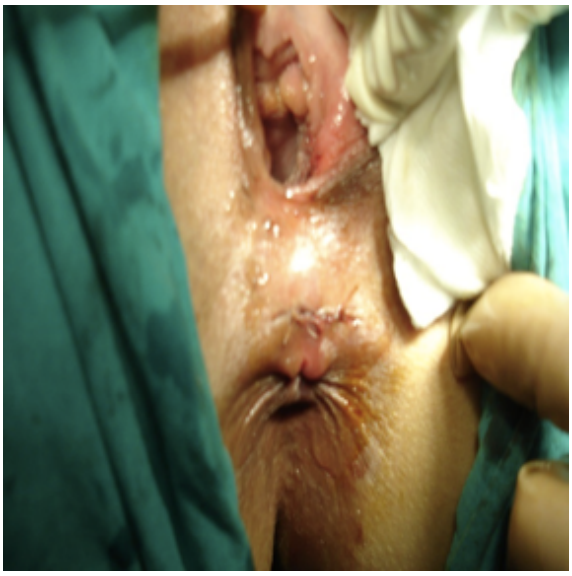

Figure 3:Postoperative Appearance

children belief that such symptoms "are to be expected" after birth [1]. The social discomfort of rectovaginal fistula is at high degree in our country, our patients have expectation to relieve their symptoms.

Although rectovaginal fistulas occur anywhere along the rectovaginal septum, they most commonly arise from the region of the dentate line and communicate with the posterior vaginal fornix. Distal of fistula extended to dentate line are more appropriately termed anovaginal fistulas but common usage terms all such fistulas as rectovaginal fistulas [1]. The fistula of our patient was located in anterior vaginal wall and dentate line.

Surgical options are available for patients with rectovaginal fistulas. Local repairs are performed through a rectal, vaginal, or perineal approach and if the surrounding tissues are deficient or unsatisfactory may be augmented with tissue transfer such as gracilis and bulbocavernosus muscle. High rectovaginal fistulas or associated with previous surgery or radiation therapies are treated with abdominal approach. Local repairs and abdominal repairs can perform with fecal diversion. Fecal diversion may also used in selected patients as the sole treatment for rectovaginal fistula [1]. Our patient had a low rectovaginal fistula. Orifices of fistula were seen on physical examination and tract was showed with guide instrument. Any other diagnostic process was not made. We decided to perform like an anorectal fistula because our experience with ligation of intersphincteric fistula tract for anal fistula is quite excessive. As much as we know that ligation of intersphincteric fistula tract method is rare for rectovaginal fistula in the literature.

The choice of repair depends on a variety of factors, including the presence of associated incontinence, the size and location of the fistula, the degree of complexity of the fistula, and the status of the surrounding tissues. All procedures for rectovaginal fistula repair have a significant failure rate; many reported series measure ultimate success rates and not initial success rates. Although fistula closure is ultimately achieved, a number of patients require more than one operation. Cigarette smoking is increasingly recognized as a predictor for adverse outcome and recurrent fistula [5,6]. Our patient had no history of smoking.

Preoperative discussion should focus on the anticipated results and at times abnormally high patient expectations need to be adjusted. Furthermore, quality of life and assessment of dyspareunia and sexual dysfunction after rectovaginal fistula surgery have not been rigorously evaluated in the majority of studies [1]. Our patient had dyspareunia and sexual dysfunction preoperatively but postoperatively hadn't these complains. Ligation of intersphincteric fistula tract is quite reliable method and can be used in rectovaginal fistula.

Declaration of conflicting interests: The authors declared no conflicts of interest for the authorship and/or publication of this article.

Funding: The authors received no financial support for the research and/or authorship of this article

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How to cite this article/Bu makaleye atıf için:
Calis H, Ozlem N. A Rectovaginal Fistula Treated By Ligation of Intersphincteric Fistula Tract Method. Acta Med. Alanya 2018;2(1):43-45.
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