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Clinical Manifestation and Surgical Management of Rectovaginal Fistula: A Case Report

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1. Introduction

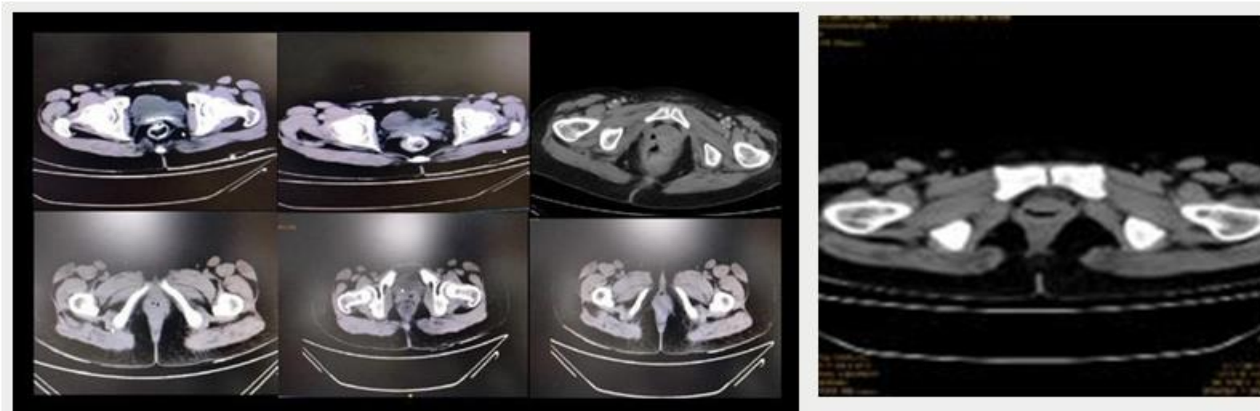
- Rectovaginal fistula formation results as a complication of an underlying disease, injury, or surgical event. Characteristics of rectovaginal fistula (RVF). vary depending on the cause of the fistula, patient factors, and the treatment received.
- The most common etiology of traumatic rectovaginal fistulas is obstetric injuries.
- Other common causes are diverticular disease. Crohn's disease, malignancy, radiation, non-surgical injuries, and foreign bodies. If the fistula is wide, it can lead to fecal incontinence. [1]

2. Case Report

- A 41-year-old female patient presented with chief complaints of passing flatus and foul-smelling discharge from the vagina for 3.5 months and passing stool from the vagina for 1 month.
- A patient underwent a vaginal hysterectomy for non-specific chronic cervicitis before 3.5 months at Rajasthan. In the postoperative period, she started passing flatus and foul-smelling discharge from the vagina. She was vitally stable when she presented to us.

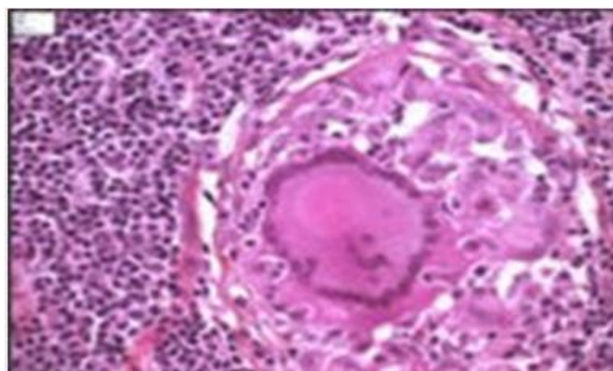
3. Investigations

All routine preoperative blood investigations were normal. CT SCAN: CT SCAN report showed 6×3 mm sized fistulous tract between the lower rectum (8.5 cm above the anal verge) and uppermost end of the vaginal vault.



4. Management

- Planned exploratory laparotomy with rectovaginal fistula tract excision, live omental placement in rectovaginal pouch with temporary transverse colostomy was done. The resected specimen was sent for histopathology.
- Post operative course was uneventful.
- Stoma started functioning on 3rd post-operative day.
- After 3-month stoma closer of loop transverse colostomy was done.
- Patient on regular follow-up and is asymptomatic.
- Histopathological report shows chronic inflammation with foreign body granuloma formation



5. Discussion

a) In the present case, the patient had an untreated uncomplicated, high rectovaginal fistula.

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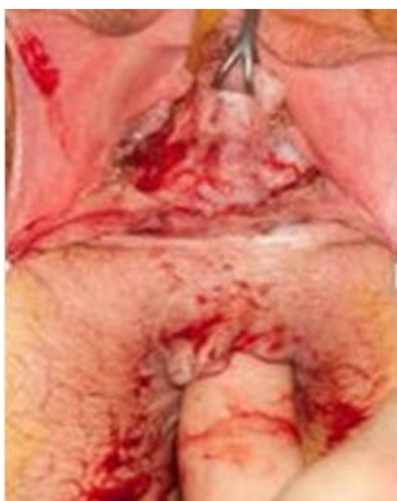
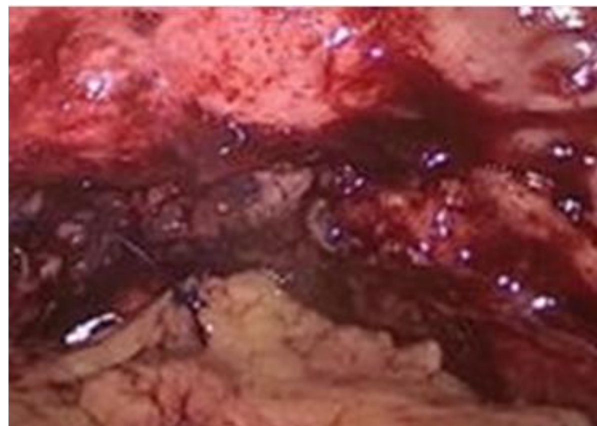
b) Classification of the fistulas is based on the location in relation to the cervix and vaginal fourchette:
- Enterovaginal fistulas
- High rectovaginal fistulas
- Midzone fistulas
- Low rectovaginal fistulas
- Supra sphincteric
- Trans sphincteric anovaginal fistulas

c) Rectovaginal fistulas are more commonly associated with Crohn's disease than ulcerative colitis. Approximately 3% of patients with ulcerative colitis develop rectovaginal fistulas. It has been reported that up to 6% of women receiving pelvic irradiation will develop rectovaginal fistulas. [2]
d) RVFs can be classified into low and high varieties. Low RVF is between the lower third of the rectum and the lower half of the vagina. A high fistula is between the middle third of the rectum and the posterior vaginal fornix. [3]
e) Most women with persistent symptomatic disease will not heal without surgical intervention.
f) The perineal approach is the preferred one for low variety, A low rectovaginal fistula, the success rates vary widely from 29 to 100%, vascularized surrounding tissue, which can be repaired with local techniques including a fistulotomy and immediate reconstitution with the endorectal advancement flap procedure for low rectovaginal fistulas. [3]



g) The endorectal advancement flap proved to result in a better primary healing rate of 85% than the mucosal advancement flap with 65%. [4]
h) High fistulas are best approached transabdominaly. High RVFs are most commonly approached by a conventional open technique.
i) Aggressive surgical treatment of RVF, including excision of track and the early use of temporary stoma leads to high success rates. [5]



6. Conclusion

A rectovaginal fistula is a vexing problem for women. The successful management of this problem depends on the etiology, size, and location of the fistula, as well as assessing the competence of the continence mechanism. Aggressive and timely surgical treatment of RVF leads to high success rates.

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