

RECTOVAGINAL FISTULA – 2

Causes

- obstetric injury: most common cause, either immediately postpartum or 7-10 days with failed repair.
- IBD: Crohn's 10% with fistula
- Anorectal surgery: vaginal hysterectomy
- Infection: perianal or Bartholin gland infection, diverticulitis, TB, LGV
- Radiation: increased with radiation for cervical/endometrial cancer

Evaluation

- ultrasound
- methylene blue
- endoscopic/contrast studies if suspect IBD
- assess sphincter status with PE, sensation, tone, manometry, ultrasound

Classification

- based on size, location, etiology
- simple: through low or mid vaginal septum, <2.5 cm diameter, trauma/infection
- complex: through high vaginal septum, >2.5 cm diameter, IBD/radiation/neoplasia

Surgical options for obstetric rectovaginal fistulas

- assess fecal incontinence
- Transanal: most commonly by advancement flap, alternative rectal sleeve procedure
- Transperineal: increase risk of disability if no sphincter injury
- Transverse transperineal: incision above sphincter complex
- Transvaginal: fistulotomy, possible advantage increased exposure

Radiation Fistulas

- important to evaluate damage to rectal mucosa
- local repair consider diversion
- option to transpose healthy, well vascularized tissue - Martius technique with bulbocavernosus, or gracilis/sartorius

Crohn's Disease

- 1st attempt drainage and placement of seton, medical treatment, removal of seton tract may close spontaneously
- evaluate rectal disease
- choice of procedure dictated by severity of disease

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July 25, 2005