Case Report

Rectovaginal Fistula: A Case Report

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Abstract: Recto-vaginal fistula occur commonly due to obstetric or surgical injuries, malignancies, inflammatory bowel disease or pelvic floor denervation besides neurological conditions .We report one case of rectovaginal fistula following coital injury.
Keywords: Rectovaginal Fistula, Coital Injury, Transvaginal Repair..

INTRODUCTION

Few problems in gynaecology cause so much personal discomfort, embarrasement and surgical isolation to women as the problem of fecal incontinence. Most of these women conceal their symptoms until the problem becomes so troublesome that they withdraw from social contacts. Recto-vaginal fistula occur commonly due to obstetric or social injuries, malignancies, inflammatory bowel disease or pelvic floor denervation besides neurological conditions [1].We report one case of rectovaginal fistula following coital injury.

CASE REPORT

A 23 years old women reported in outdoor on with complaints of passage of faeces per vaginum since the previous night. She gave no history of trauma, fever or any previous pain at local site. Her bowel and bladder habits were normal. Per vaginal examination there was a vertical tear of 2 cm in the midline in the lower 1/3 of posterior vaginal wall, 1cm above the introitus. The margins were fresh, with blood oozing from them. Per rectal examination revealed a tear in the anterior rectal wall and the finger entered the anterior vaginal wall. After taking the patient in confidence, she gave history of forceful anal intercourse by her husband who was intoxicated. She had struggled in pain which had caused the trauma. A diagnosis of Type IV recto-vaginal defect (the fistula was in the lower 1/3 of the recto-vaginal wall and the perineum was intact) was made. Since the trauma was fresh, she was posted for repair operation the next day after bowel preparation and counselling the couple for the future.

Trans vaginal repair of the recto vaginal fistula was done. The vaginal tear was extended upto the introitus. Vaginal flaps were raised; dissection was done in the recto vaginal plane. Defect in the rectal wall was identified and closed by 3-0 delayed absorbable suture in two layers. Perirectal fascia was approximated in the midline and vaginal mucosa was closed with 3-0 delayed absorbable continuous locking suture. Patient stood operation well. She was fed clear liquids for five days and then kept on a low residue diet. Stool softeners were advised. Patient made an uneventful recovery with complete faecal continence.

Fig.: Photograph of the Recto-Vaginal Fistula showing Uterine Sound Passed from the Anus into the Fistula

DISCUSSION

Recto-vaginal fistula commonly occurs as a result of obstetric or surgical injuries, inflammatory bowel disease, and pelvic floor denervation besides certain neurological conditions. Traumatic injury is more often a side straddle injury in young girls may result in simple or extensive laceration of the perineum [1]. Post-coital recto-vaginal fistula has ben reported as an aftermath of vaginal douching with potassium alum [2]. Counselling of the couple is essential to prevent a recurrence. Examination under anaesthesia is advisable so that appropriate repair can be made, looking carefully for lacerations of the anal sphincter and rectum as well as

other structures [1]. Repair may be done by transvaginal or transperineal route.

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