Management of Rectovaginal Fistula

BH Pienaar
Differentiate

• Rectovaginal fistula
  – Above the dentate line
  – More common
  – Important to distinguish from

• Ano vaginal fistula
  – Treatment is different
  – Uncommon
  – Sphincter involvement
  – Medical management if secondary to Crohn’s
Classification
Rectovaginal Fistula

• Location
  – Low/Perineal
    • Approach perineal
  – High (middle/upper third rectum)
    • Transabdominal approach
Classification
Rectovaginal Fistula

• Aetiology
  – Obstetric trauma
  – Radiation injury
  – Iatrogenic trauma (PPH)
  – Neoplastic
  – Inflammatory bowel disease (Crohn’s)

• Size
  – Small < .5 cm
  – Medium .5-2.5 cm
  – Large . 2.5 cm

• Combination of the above.
  – To decide the approach
Pathophysiology

– Obstetric trauma
  • Pressure
  • Infection of episiotomy
  • Failure to correct perineal defects
– Stapled resection
  • PPH
– Crohn’s disease
  • Perirectal abscess
– Diverticulitis
  • Pelvic/Perirectal abscess
Pathophysiology

Radiation therapy in pelvic malignancy
Most difficult

Other risk factors
Previous pelvic surgery
Diabetes
Smoking
Symptoms

Faeces and flatus through vagina

Vaginitis/Cystitis

Asymptomatic (Faecal consistency)

“Incontinence”
Examination

Standard routine examination
  Size
  Location
Sphincter function
Vaginal tampon/Rectal methylene blue
Barium enema (diluted)
CT scan
Endorectal/Vaginal sonography
Biopsy
Anatomy

Rectovaginal septum

Anal sphincter complex

Perineal body
Preparation

Complete mechanical bowel preparation

Neomycin advocated by some

Systemic antibiotic use
Local repair

**Trans anal advancement flap repair**

Patient proned/operating anoscope

- Flap contains mucosa and submucosa
- Mucosal fistulous opening excised
- Approximation of muscle wall of rectum
- Flap sutured interrupted

Vaginal wall left open

Sphincter status
Local repair

Trans vaginal advancement flap repair

Patient lithotomy

Flap contains posterior vaginal wall

Mucosal fistulous opening excised

Approximation of levator ani

Flap sutured interrupted
Transabdominal

Essential for high complicated fistula
  Radiation
  IBD
  Diverticular disease
Affected bowel must be resected
Omentum as interposition buttressing structure
Other

Gracilis interposition
- 75% success rate (no Crohn’s)
- 33% success rate (with Crohn’s)

Martius graft
- (1928: pedicled bulbocavernosus fat pad)

Colostomy with/without proctectomy
Simple fistula

Assess sphincter

Defect

- Sphincter repair with advancement flap
  - Redo

No Defect

- Advancement flap
  - Redo

- Inter position with martius graft or gracilis
- Proctectomy and coloanal anastomosis
Crohn’s disease

Control sepsis

Optimise medical treatment with gastroenterologist

Assess rectum

Rectum spared

Local repair

Failed

Consider further local repair

Mild disease

Minimal symptoms

Conservative

Severe disease

Consider attempt at local repair

Failed or unsuitable

Stoma +/- proctectomy
New possibilities

**Permacol\(^{(TM)}\) Injection**

Particles of milled Permacol\(^{TM}\) suspended in saline

Crosslinking step post milling

Non-allergenic - no pre-use skin test required

Easy to use - passes readily through 19 gauge needle
Transvaginal advancement flap
Levator ani approximation
RECTAL ADVANCEMENT FLAP
Purpose of the Exercise

Not to have the original defect and the repair suture line overlapped
Thank you