



# Management of Rectovaginal Fistula

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# 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 prone/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

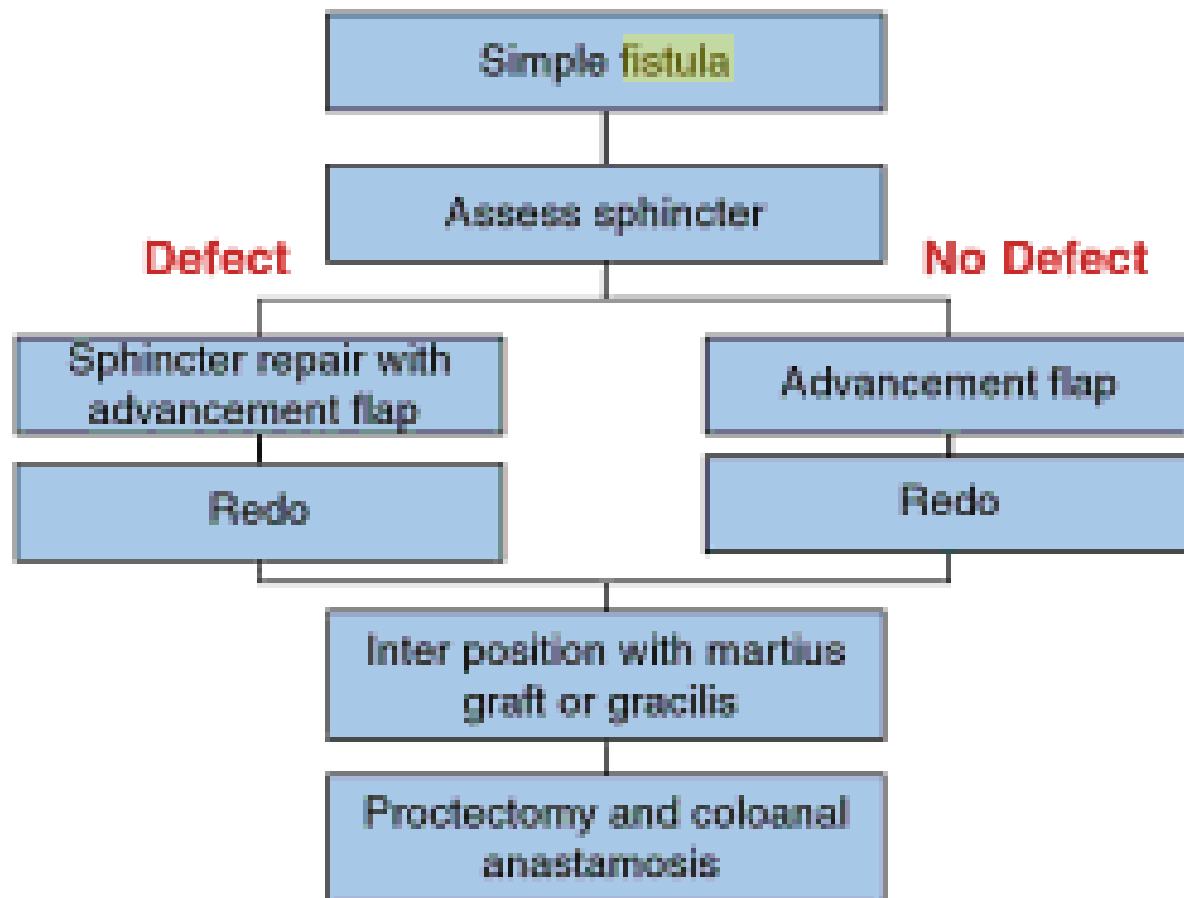
75% success rate (no Crohn's)

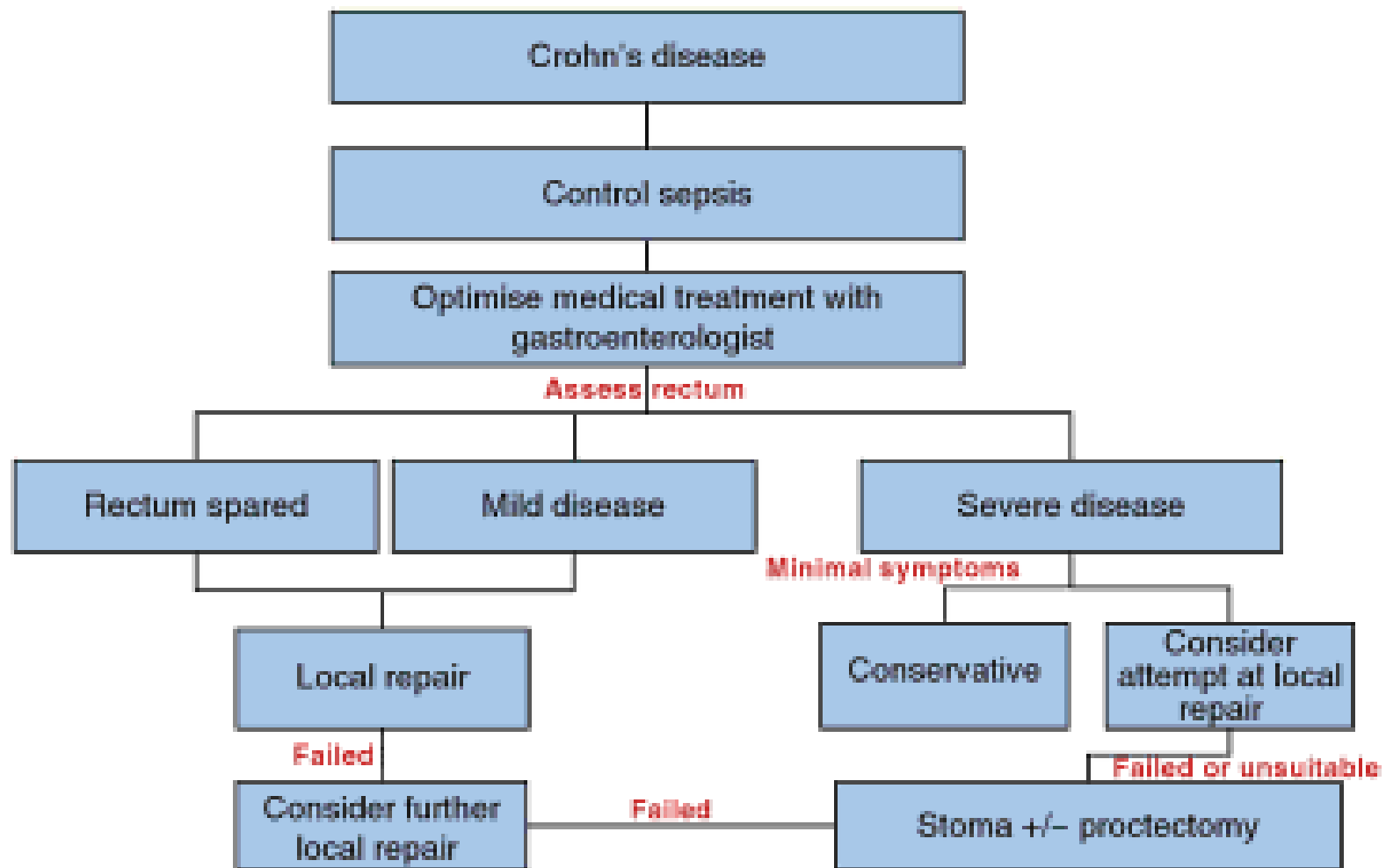
33% success rate (with Crohn's)

Martius graft

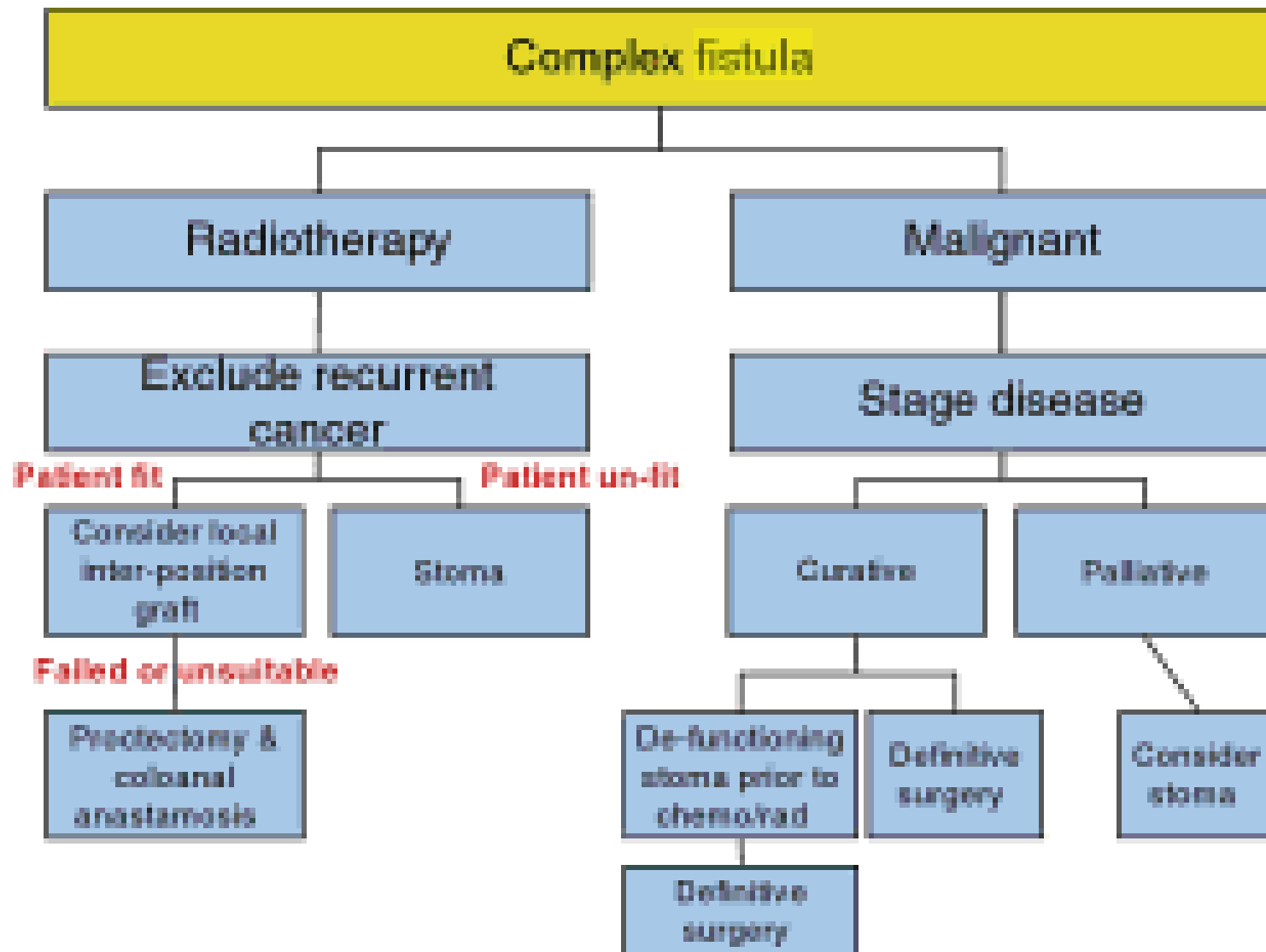
(1928: pedicled bulbocavernosus fat pad)

Colostomy with/without proctectomy









# New possibilities

## Permacol<sup>TM</sup> Injection

Particles of milled Permacol<sup>TM</sup> suspended in saline

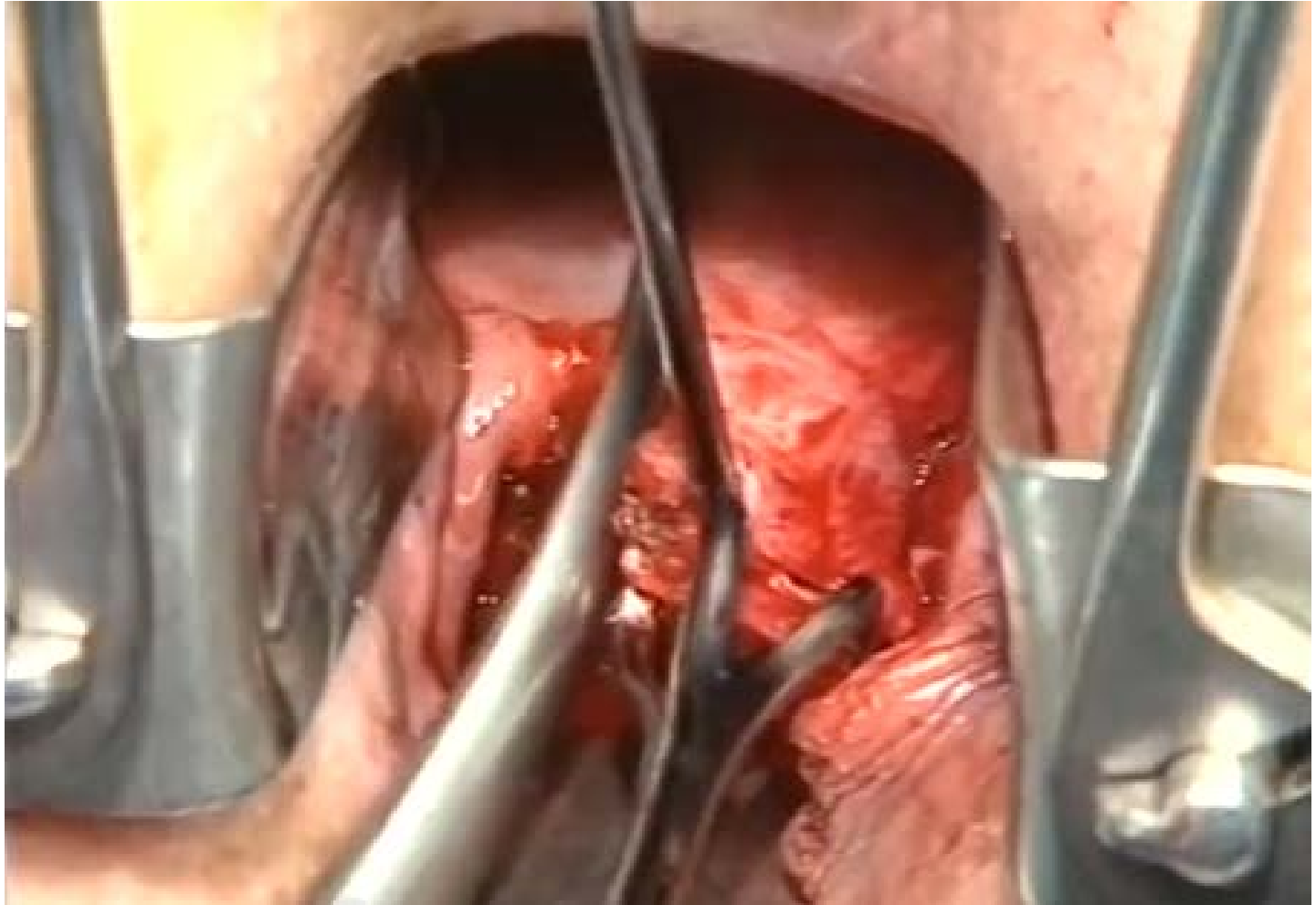
Crosslinking step post milling

Non-allergenic - no pre-use skin test required

Easy to use - passes readily through 19 gauge needle

# Transvaginal advancement flap



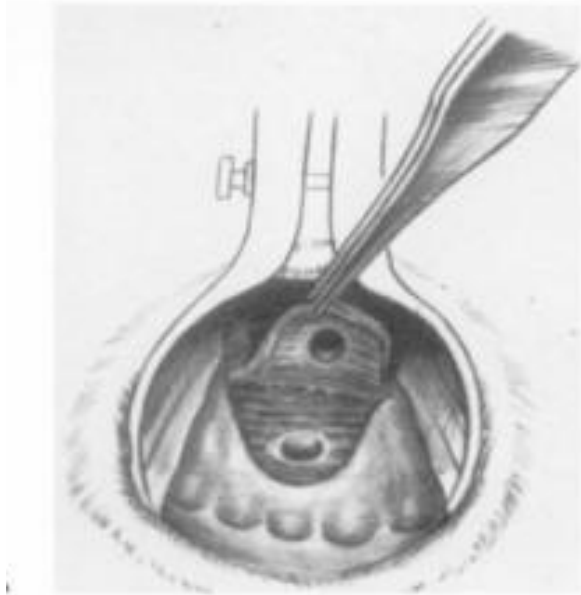


# Levator ani approximation

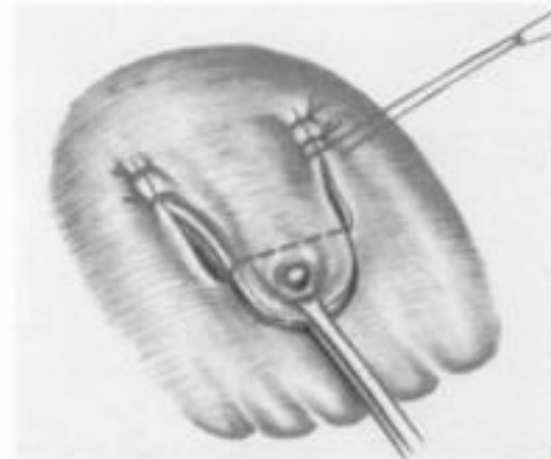




## RECTAL ADVANCEMENT FLAP



B



D

# Purpose of the Exercise

**Not**  
to have the  
**original defect**  
and the  
repair suture line  
overlapped



# Thank you

