RECTO-VESICAL FISTULA IN A WOMAN

(A Case Report)

by

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Recto-vesical fistula in women is a rare entity and the relative occurrence in women is only a third of that in men. This is due to the lesser incidence of diverticulitis in women (Avery Jones and Gummer, 1961) and the protective interposition of the uterus between the bladder and the bowel. Fitzpatrick (1961) stated that the possibility of such a disease should be suspected in women complaining of vesical symptoms with recto-sigmoid disease where vaginal hysterectomy has been done. Pattillo, Mattingly and Messinger (1966) described vesico-cervico-rectal fistula as a new gynaecologic entity. We present here a case of recto-vesical fistula with the presence of the uterus and the cervix.

Case Report

Smt. M., aged 52 years, was admitted on 16-5-70 with complaints of swelling in perianal region and lower part of the abdomen for 6 years, passage of urine per rectum and dysuria 2 months, and severe intermittent pain in the lower abdomen radiating down the rectum and the thighs with constipation and intermittent fever for 2 months. During the last 6 years she was treated for lower abdominal pain and dysuria off and on with antispasmodics and urinary antiseptics. She also had urethral dilatation 2 years ago with only slight relief. There was no history of haematuria or acute abdomen. She was nulliparous and had her menopause 10 years ago. Her previous menstrual cycles were regular. No history of tuberculosis could be traced either in her or her family.

On examination, she was an ill-looking, anaemic woman. Systemic examination did not reveal any abnormality except the enlarged smooth liver, which was not tender. The lower abdomen was diffusely full. There was no renal swelling or tenderness.

On pelvic examination external urethral meatus was normal, vaginal mucosa was thin, uterus was retroverted and atrophic, adnexae were not palpable.

During rectal examination rectal mucosa was found to be healthy, urine mixed with faecal matter was seen coming out.

Her E.S.R. was 43 mm. average, blood urea was 36 mg. per cent and Hb. 9 Gm per cent.

On cystoscopy there was residual urine of about 10 ml., bladder capacity was about 6 ounces. Patchy inflammation was seen all over the bladder surface. Ureteric openings were not visualised because of faecal matter in the bladder. There was an opening on the posterior wall of the bladder about 1 cm. in diameter with irregular firm margins.

Sigmoidoscopy was done under general anaesthesia. Sigmoidoscope could be passed

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only upto about 10 cms. There was a stricture at that level. No fistula could be detected up to that level. The index finger was then negotiated beyond the stricture which went anteriorly into the bladder.

Dye test: 1 per cent methylene blue injected into the bladder soaked the gauze put inside the anus.

Intravenous pyelography showed kidneys and ureters on either side to be normal. Bladder was visualised normally.

Cystography and barium enema: Cystography alone showed pouching of the bladder wall posteriorly, Barium enema was done simultaneously which revealed the fistulous tract between the bladder and the rectum (Fig. 1). Urinary culture for A.F.B. was negative. Urinary cytology for malignant cells was negative.

Laparotomy was done on 24-6-1970 after preliminary pre-operative preparation of the patient, Pelvis was plastered with adhesions. There was a fistula between the posterior wall of the bladder and upper part of the rectum near its junction with the sigmoid colon. Uterus was retroverted and deeply buried under the adhesions, thus obliterating the pelvic peritoneal pouches. Intestines were congested. Mesenteric glands were not enlarged. The ureters of both sides were traced down to the bladder. The plane of cleavage between the bladder and the rectum was found with difficulty and the bladder was dissected free from the anterior rectal wall. The edges of the bladder opening were freshened and closed in two layers. The upper part of rectum and adjoining part of the sigmoid colon were mobilised on all sides. Dense fibrosis encountered during the dissection was more marked on the left side of the rectum than the right. The part of the rectum with the fistula and the stricture just below it was excised transversely and end to end anastomosis was done. The uterus, which was lying low into the pelvis bound down by adhesions was freed and reposed back. 300 cc. of blood transfusion was given. The patient made an unventful recovery; the drainage tube was removed after 96 hours. Bladder catheter was removed after 10 days. She was discharged on 13-7-1970 in good general condition with advice to take fersolate and multivitamin tablets. High protein diet and cortisone was given for 4 weeks after the removal of stitches in decreasing doses. Urine culture was sterile and stool examination was normal. Follow-up examination was done on 15-9-1970, 1-6-1971 and 7-1-1972 when she was seen well and free from symptoms.

Discussion

Patients with the above complaints seeking gynaecological advice often present with vague bladder and bowel symptoms. The diagnosis before the vesico-intestinal fistula develops is difficult due to the fact that the early cases are usually missed if proper attention is not paid to such symptoms. Fitzpatrick (1961) has drawn attention to this aspect while commenting on the diagnosis of vesico-intestinal fistulae. Our patient complained of pain in the lower abdomen, radiating down the rectum, with swelling of perianal region due to rectal prolapse caused by straining, dysuria, frequency, constipation and low-grade fever which was empirically treated outside for 6 years with transient, relief. Subsequently, the pain increased and she noticed passage of urine per rectum, when she sought our advice. Passage of faecal particles in the urine and pneumaturia have been described as cardinal symptoms of this disease which were not present in our case. It was because of the low situation of the fistula in the rectum. The diagnosis was confirmed by palpation under general anaesthesia, cystoscopy, cystography, sigmoidoscopy, barium enema and the dye test.

As regards the operative procedure the repair of the bladder fistula and resection of the gut with end to end anastomosis was done in one stage as suggested by Best and Davies (1969) though much has been commended in the literature for a preliminary colostomy and then repair.

Recto-vesical fistula may have a con-

genital, traumatic inflammatory or neoplastic background. In the present case there was marked stenosis of upper part of the rectal wall beyond which this sigmoidoscope could not be passed. Histologically, intense fibrosis and round cell infiltration below the rectal mucosa were the only finding (Fig. 2). The features of Crohn's disease, tuberculosis or malignancy were searched for but none could be detected. It is difficult to account for the occurrence of the fistula so low down between the rectum and the bladder. The atrophic uterus was buried down posteriorly and played no protective part. It was presumed that a distally spreading diverticulitis was the underlying cause. The patient was followed up to one and half years and she was found in good health. This indicates that whatever might have been the pathology responsible for the fistula it was benign, localised, non-recurrent and amenable to the treatment done.

References

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See Figs. on Art Paper V