COITAL INJURY—A RARE CAUSE OF RECTOVAGINAL FISTULA

by

NARESH SEHGAL,* M.B.,B.S., M.D., D.G.O.; P. SAPRA,** M.B.,B.S., M.D.

and

L. OOMEN,*** M.B.B.S., M.D.

Introduction

Rectovaginal fistula is a common place observation in practice of obstetrics and gynaecology (Howkins, 1962). The present communication records a case of rectovaginal fistula resulting from an injury during sexual intercourse in a newly married female.

CASE REPORT

K.K.; 21 years old female, was admitted as an emergency on December 7, 1973 at 8 p.m. with an hour's bleeding from the vagina. She was perfectly alright before. Immediately following coitus, she had these symptoms. The bleeding was moderate.

She was married for the past 11 days. She had coitus on two occasions earlier after marriage. She did not have any difficulty during the coitus on any occasion. There was no history of any injury to the rectum or the vagina, in the past. Her bowel habits were normal. There was also no history of bleeding per rectum.

Her menarche had started at the age of thirteen. Her menstrual cycles were regular, lasting for 3—4/32 days. She had the last menstrual period on November 26, 1973.

On examination her general condition was good. The pulse rate was 90 per minute and was regular. Her blood pressure was 120/80 mm. of mercury. The systemic examination did not reveal any abnormality.

On vaginal examination a vertical tear of 3.5 centimetres length, extending from introitus to the posterior vaginal wall was seen. On further exploration, it was seen that the rectum was also affected. It was possible to pass the examining finger from the apex of the vaginal tear down to the rectum and it could be hooked out through the anus (Fig. 1). The anal sphincters were, however intact. The fistula of one centimetre by one centimetre in the rectum was confirmed on speculum examination.

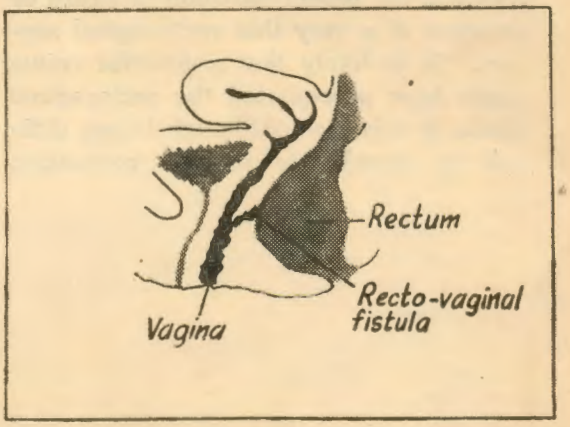

Fig. 1

The bleeding was controlled by packing the vagina. The patient was instructed to consume low residual diet only. Additionally, she was administered broad spectrum antibiotic. The bowels were sterilized by gastrointestinal antibiotic.

The rectovaginal fistula was repaired by flap-method. The postoperative period was smooth and afebrile. The patient was dischared after 10 days.

*Medical Officer in Obstetrics & Gynaecology,
**Medical Officer Family Planning.
***Obstetrician and Gysaecologist.
From St. Stephen Hospital, Tis Hazari. Delhi-6.
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Discussion

Rectovaginal fistula consequent to trauma sustained during sexual intercourse seems to be a rare situation, as we were unable to find such an instance in the Indian literature. In order to understand its pathogenesis it is worthwhile to recall the anatomical relations of the vagina and the rectum. Anatomically, the middle third of the posterior vaginal wall is in direct proximity to the ampulla of the rectum. Thus, any mechanical injury or trauma to the posterior vaginal wall can involve the rectum and in turn result in formation of a rectovaginal fistula. It is imperative to consider the possibility of a congenital abnormality such as partial defect in the proper partition of cloaca or presence of a very thin rectovaginal septum. It is likely that a forceful coitus might have precipitated the rectovaginal fistula in this case. Although it was difficult to corroborate such a contention either on the basis of history and/or local examination.

Majority of rectovaginal fistulae are known to occur after obstetrical injuries like complete tear of the perenium or from operations for old complete tears. Besides, certain gynaecological conditions such as tuberculosis, carcinoma of the vagina and carcinoma of the cervix infiltrating the posterior vaginal wall may cause rectovaginal fistulae. But the present case needs emphasis as such a situation is only occasionally encountered in practice.

Acknowledgement

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References

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