# A CASE REPORT OF HIGH COLO-VAGINAL FISTULA FOLLOWING TRAUMATIC VAGINAL DELIVERY

by

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*Summary*

This article presents a case report of the investigations and treatment undertaken for a colo-vaginal fistula resulting from traumatic vaginal instrumentation during childbirth at a mofussil place.

**Case Report**

Mrs. M.I., 22 years old, was admitted with the complaint of continuous discharge of faeces from the vagina following a prolonged difficult labour during which some instrumental intervention was done resulting in a stillbirth. The faecal soiling developed 24 hours after delivery.

On examination, her general condition was good. On vaginal examination, the uterus was anteverted, normal sized, with restricted mobility. On speculum examination, faecal matter was seen discharging through an opening high up in the left fornix, but not well visualised. On rectal examination, the site of the fistula could not be reached. Routine investigations were within the normal limits.

**Specific Radiological Examinations**

Barium enema showed the fistula to be at a high level of the colon. However the fistulous tract was not clearly visualised. (Plate 1). Hence the following specific investigations were carried out.

Though the sigmoidoscope the height of the opening was measured and found to be 15 cms from the anal opening and about 0.5 cms. in diameter. A Foley's catheter was negotiated from the vagina into the fistulous opening. The tip of the catheter subsequently emerged out of the anal orifice.

The dye barium sulphate was injected through the Foley's catheter and antero-posterior and lateral plates were taken after maintaining a tension on both ends of the catheter to avoid kinking. (Plates 2 and 3).

The highest level of the fistula was found to be at the second sacral vertebra.

A condom fixed onto a rubber tube was introduced high into the rectum and barium sulphate was injected into it. With the Foley's catheter in place antero-posterior and lateral plates were taken. (Plates 4 and 5). Finally, the Foley's bulb was filled with radioopaque dye and the other end of the tube pulled at so that the bulb was apposed against the site of fistula. (Plate 6).

Having localised the site of the fistula, abdominal approach was obviously decided upon.

**Operative Procedure**

Preoperatively meticulous bowel preparation was carried out. Abdomen was opened by the left vertical paramedian incision. Uterus and adnexa were identified and held away. Adhesions with the posterior surface of the uterus upto the fistulous tract were identified and dissected after tracing the left ureter. The sigmoid colon was mobilised. Area of fistula was defin-

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ed by putting a finger through the vagina. Vagina was closed by continuous catgut sutures and sigmoid colon by 5/0 linen. No colostomy was undertaken.

Postoperatively patient started passing faeces normally by about the seventh day. Follow-up after two months did not show any leak.

*Discussion*

Though a number of traumatic fistulae following unskillfull obstetric intervention have been reported from developing countries, high fistulae of the type reported above are not commonly seen. The exact determination of the fistula is quite important in planning the surgical approach, vaginal or abdominal. (1, 2). Since the barium enema did not demonstrate the exact site and level of fistula satisfactorily, the specialised techniques mentioned above were adopted.

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*See Figs. on Art Paper XI-XII*