CONGENITAL RECTO-VAGINAL FISTULA

(Report of Two Cases)

by

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Congenital ano-rectal anomalies are very rare, occurring approximately in every 5,000 births (Bradham 1958). These anomalies are rarer still in gynaecological practice because these anomalies occur commonly in males and because now-a-days conditions are diagnosed early in life and corrected surgically by surgeons. We wish to present 2 cases of congenital recto-vaginal fistula treated in Medical College and Hospitals, Calcutta in 1974.

CASE REPORT

Case 1

Smt. H.D., 16 years single girl was admitted on 26-4-1974 in Gynaecological Unit of Medical College, Calcutta with complaints that since her birth she was passing stool through vagina and there was no separate bowel passage. Her menstrual and bladder function were normal and there was no faecal incontinence. As she was contemplating to get married she wanted to rectify the defect. On examination she was found to be a perfect female from physical and endocrinal point of view. On local examination, a 'Vestibular Ectopic anus' was detected. Usual pre-operative investigations, including Intravenous Pyelography was normal.

Case 2

Smt. B.D., 14 years girl was transferred from Surgical Unit of Medical College to Gynaecological Unit on 3-6-1974 for difficulty in holding loose stool, menstrual blood and faeces were coming through the same passage. Congenital recto-vaginal fistula was diagnosed in the surgical side and they attempted to pull down the fistula locally. Failing in first attempt they did a colostomy and tried to pull down the fistula. When two attempts failed they transferred the case to gynaecological unit. On examination she was perfectly healthy. On local examination there was scarring of the perineum and the site of the fistula was situated about 2 cm above the vaginal introitus. Usual preoperative investigations including intravenous pyelography was normal.

Management: Preoperative management for both the cases were same as for aquired recto-vaginal fistula.

Operative Procedure for Case 1: Patient was put in lithotomy position under general anaesthesia. The mucosa of the vagina was incised around the anus, thus separating the epithelium of 2 channels. A rubber tube about the same diameter as the anal canal was passed into the anal canal for a short distance and the edges of the anal walls sutured to it. Anal canal and lower part of the rectum was mobilized for a sufficient distance to permit it to be drawn down to its normal place. A transverse incision was then made at the new proposed site for the anus and a canal was fashioned in the fibro-fatty tissue of the perineum, down which the rubber tube and anal canal were pulled down and fixed to the surrounding tissues by inturrupted stitches.

For case 2, slight modification was done. In first stage a tunnel was made by the posterior vaginal mucosa from the fistula opening to vaginal introitus by using Warren Flap technique

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for repair of complete perineal tear. Second stage of the operation was done 3 weeks later and the technique was same as described in case 1.

Post-operative: (1) Rubber tube was removed on 7th day. (2) Gradual dilatation of the new anal opening. (3) Other postoperative managements were like that for acquired recto-vaginal fistula. Follow up report upto 2 years were satisfactory with perfect faecal continence.

Discussion

Congenital recto-vaginal fistula is a rare condition. The communication may be small or the full lumen of the bowel may open into the vagina. Communication may be above or below levator ani-muscle. A high fistula is rarely big enough and often requires colostomy and the condition is usually tackled early in neo-natal life because of intestinal obstruction. When the opening is big, one may expect incontinence but it is remarkable how little incontinence exists. Two cases described here are of low fistula type and the case 1 was fully continent and case 2 was finding difficulty in holding loose stool. Congenital recto-vaginal fistula may be associated with anomalies of genito-urinary tract, cardiovascular and urinary system. Reported incidence of such associated anomalies varies from 27-72 per cent cases, commonest being urinary tract anomalies. Both the cases had I.V.P. but no such anomalies were detected. Opinion regarding the favourable time for surgical interference for such anomaly varies. It is best to defer operation until after puberty to permit the vagina to grow enough for intravaginal manipulation except where faecal impaction of fistula result in development of secondary megacolon. There are many who advocates dilatation of small fistula but according to Santulli (1951) is a dangerous procedure and may lead to cicatrix formation. Both the cases reported here came after puberty. Surgical treatment of congenital recto-vaginal fistula aims at providing anus of normal calibre at normal site with normal sphincteric control. Keeping in mind the above principles, operation was designed for the cases reported here. For case 1 slight modification of Rizzoli's operation was done and for case II combined Warren Flap method for complete perineal tear and Rizzoli's operation was performed. Ultimate result in both the cases were satisfactory as they have two separate passage and normal faecal continence. There are many who can argue about the sphincteric control of the newly formed anus. Harkin (1942) believes that most, if not all, of these patients have good anal sphincter. The cases described above had perfect sphincteric control after operation, proves the fact that sphincter develops from anal tubercle which has nothing to do with the developmental defects encountered with congenital recto-vaginal fistula.

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