CONGENITAL RECTO VAGINAL FISTULA

(Report of Two Cases)

by

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Congenital ano-genital anomalies are very rare, occurring approximately in every 5000 births (Bradham, 1958). These anomalies are rare in gynaecological practice because these anomalies occur commonly in the male and now-a-days conditions are diagnosed early in life and corrected surgically by Neo-natal Surgeons. Two cases of Congenital recto-vaginal fistula treated in Medical College & Hospitals, Calcutta in 1974 are reported.

CASE REPORT

Case 1

Sm. H. D. 16 years, unmarried girl was admitted on 26-4-74 in gynaecological unit of Medical College, Calcutta that since her birth she was passing stool through the vagina and there was no separate bowel passage. Her menstrual and bladder function was normal and there was no foecal 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

Sm. B. D. 14 years girl was transfered from Surgical Unit of Medical College to Gynaecological unit on 3-6-74 for difficulty in holding loose stool and both menstrual blood and faeces were coming through the same passage. Congenital rectovaginal fistula was diagnosed on 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 intravenus pyelography was normal.

Management: Preoperative managements for both the cases were same as acquired recto-vaginal fistula.

Operative Procedure

Case 1

Patient was put in lithotomy position under general anaesthesia. The mucosa of the vagina was incised aroung the anus, thus separating the epithelium of two channels. A rubber tube 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, through which the rubber ube and anal canal were pulled down and fixed to the surrounding tissues by inturrupted stiches.

Case 2

In the first stage a tunnel was made by the posterior vaginal muscosa from the fistula opening to vaginal intraoitus by using Warren Flap technique for repair of complete perineal tear. Second stage of the operation was done 3 weeks after the first attempt and the technique was same as described in case 1.

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Post-operative: Rubber tube was removed on the 7th day. Gradual dilatation of the new anal opening other post-operative managements were like that for acquired rectovaginal fistula.

Follow up: report for 2 years was very satisfactory with perfect foecal continence.

Discussion

Congenital recto-vaginal fistulae are rare. The communication may be small or the full lumen of the bowel may open into the vagina. Communication may be above or below the levator anii muscle. A high fistula is rarely big enough and often require colostomy and the condition is usually tackled early in neo-natal life because of intestinal obstruction. Such this type of fistula are not usually encountered in adolescence. When the opening is big, one may expect incontinence but it is remarkable how little incontinence exists. 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 gestrointestinal tract, cardio-vascular and urinary systems. 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 to permit the vagina to grow enough for intravaginal manipulation except where faecal impaction of fistula results in development of secondary megacolon. There are many who advocates dilatation of small fistula but according to Santulli (1957) is dangerous procedure and may lead to cicatrix formation. Both the cases reported here came after puberty so there was no problem. 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 principle, operation was designed for the two cases. For case 1, slight modification of Rizzoli's operation was done and for case 2 combined Warren flap method for complett perineal tear and Rizzoli's operation was performed. Ultimate result in both the cases were very satisfactory as they have two separate passages and normal faecal continence. There are many who argue about the sphincteric control of the newly formed anus. Harkin (1942) believes that most if not all of these patients are equipped with good anal sphincter. The cases described above had perfect sphincteric control after operation proves the fact that sphincters develops from anal tubercle which has nothing to do with the developmental defects encountered with congenital recto-vaginal fistula.

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