CONGENITAL URO-GENITO-RECTAL ANOMALY

(A Case Report)

by

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Introduction

The association of congenital recto-vaginal fistula with primary amenorrhoca due to vaginal deformity, uterus didelphys and anomaly of the urinary tract is very rare. A high fistula is rarely big enough and is rarely encountered in adolescence.

CASE REPORT

Km. B.D., 14 years old unmarried girl presented at the gynaecological outpatient department of our hospital on March 31, 1980 with pain in abdomen, constipation, primary amenorrhoea and a common passage for faeces and urine since birth. She had been treated by a surgeon at the age of 5 days and later on, medically in the hospital a number of times for features of subacute intestinal obstruction. At the age of 13 years she developed acute pain in the abdomen which recurred periodically every month for 8-9 months and subsequently became a constant dull ache in the lower abdomen. Her height was 5 feet, weight 40 kg and the secondary sex characters were normally developed. There was a tender lump in the lower abdomen extending 5 inches above pubic symphysis and deviated towards the right side. On pelvic examination, absence of anus was detected (Fig. 1). Internal examination was painful and difficult. All the routine investigations were within normal limits. She was examined under anaesthesia and it was found to be a case of congenital rectovaginal fistula and cryptomenorrhoea due to transeverse vaginal septum.

Operative Procedure

(I) Laparotomy was done under general anaesthesia. The pelvic colon was found to be enlarged and occupying central position behind the bladder. It was a case of uterus didelphys, each uterus situated on either side of the pelvic colon. The left uterus had a bluish cystic adnexal lump (Fig. 2). The round ligaments on either side were thick and strong. The right kidney was rudimentary and the right ureter was absent. The left kidney was normal in position and size and the left ureter, which was looking normal, was traced upto the bladder.

(II) The left uterus with adnexal mass was sacrificed (Fig. 3) which on cut section revealed haematometra and solid cervix (Fig. 4). Rectum was dissected from its surrounding structures to make it freely mobile upto its opening in the vagina.

(III) An incision was made in the uterus (right) at the level of internal os and a rubber tube was insertel through it which entered the cervix and expanded vagina.

(IV) Placing the patient in the lithotomy position, the "pull through" operation was completed

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by constructing a new artificial anus 1 inch below the introitus (Fig. 5).

(V) The vaginal septum was incised around the pointing tip of the rubber tube and it was fixed in position. Old tarry blood escaped from the tube confirming its patency and position (Fig. 6).

(VI) The rubber tube was removed after 8 days and a mould was used daily to keep the vaginal opening patent. The anal sphincteric action, though poor during postoperative period, improved gradually and was satisfactory by the time she was discharged from the hospital. Stitches were removed on the 8th postoperative day and she was discharged after 2 weeks with instruction to use the vaginal mould regularly.

(VII) After a couple of months she returned with the problem of secondary amnorrhoea. On examination the vaginal opening was found to be closed. It was reopened under anaesthesia and incised so as to enlarge the original opening. Vaginal dilatation was done three times thereafter under anaesthesia over a period of nine months. The patient now has regular menstruation and has no problem in defaecation.

See Figs. on Art Paper VII