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Case Report

Silent suffering: a late presentation of obstetric fistula

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ABSTRACT

Rectovaginal fistulas are uncommon and account for less than 5% of all anorectal fistulas. Obstetric causes include perineal laceration, episiotomy, assisted vaginal delivery, prolonged labour, and trauma to the genital tract. They usually present with fecal incontinence immediately or within 7-10 days. Other causes include inflammatory bowel disease, diverticulitis, gynaecological surgeries, malignancy, and post-irradiation changes.

Keywords: Rectovaginal fistula, Assisted vaginal delivery, Prolonged labour, Fecal incontinence

INTRODUCTION

Rectovaginal fistula (RVF) is an abnormal epithelial-lined tract between the rectum and vagina. Obstetric causes include perineal lacerations (unrecognized, improperly repaired, or secondarily infected), forceps or vacuum-assisted delivery, and obstructed labour. Non-obstetric causes include Crohn's disease, malignancy, post-radiotherapy, post-surgical complications (e.g., following endometriosis surgery), anorectal suppurative diseases, tuberculosis (TB), lymphogranuloma venereum (LGV), HIV, cytomegalovirus (CMV), and prolonged use of pessaries. Obstetric anal sphincter injuries (OASI) are the most common cause of anal incontinence in women. These are severe perineal tears specifically third- and fourth-degree tears that can damage the anal sphincter muscles. Only 0.1% of vaginal deliveries result in RVF. Low RVF (simple) involves the lower one-third of the rectum and the lower half of the vagina. High RVF (complex) involves the middle one-third of the rectum and the upper vagina.[1]

RVFs can be classified by size: small- less than 0.5 cm in diameter, medium-0.5–2.5 cm in diameter, and large-more than 2.5 cm in diameter. Risk factors for OASI include baby birth weight >4 kg, persistent occipito posterior, prolonged second stage of labour, shoulder dystocia, midline episiotomy, forceps delivery. Symptoms include passage of flatus or stools through the vagina, vaginitis or recurrent UTI, foul smelling vaginal discharge, fecal incontinence due to associated anal sphincter damage, local irritation, inflammation, dyspareunia, psychosocial and sexual dysfunction.[1] Diagnosis is made by bidigital rectovaginal examination. If there is any doubt regarding the degree of tear, it should be classified as a higher degree. Any concomitant sphincter injury should be repaired simultaneously, as this improves the success rate of RVF repair.[2]

CASE REPORT

A 37-year-old female, para 3, live 2, D1A3, with a history of three previous normal vaginal deliveries, presented to SRMC with complaints of passage of stools from the vagina for the past one month. Her last childbirth was one year ago and was a spontaneous vaginal delivery with an episiotomy. The baby's birth weight was 3.025 kg, and the total duration of labour was 14 hours. Over the past month, the patient noticed soiling of clothes with stools and stool-stained vaginal discharge. She also reported involuntary passage of stools during urgency, although she denied any altered bowel habits. Additionally, she gave a history of genital trauma during childhood for which suturing was performed. With adequate bowel preparation and antibiotic coverage, a rectovaginal fistula (RVF) repair

was performed. Intraoperatively, a fistulous tract was noted between the vagina and rectum at the 2 o'clock position. The tract was excised by dissecting the vaginal mucosa, rectovaginal fascia, and anal mucosa separately. The ends were freshened and sutured in layers using 2-0 vicryl. Postoperatively, the patient was kept nil per oral (NPO) for 24 hours, followed by clear liquids for 48 hours, and then gradually advanced to a soft solid diet. She resumed normal bowel and bladder habits by postoperative day (POD) 4 and was discharged on POD 6. Figures 1 and 2 represents the pre-operative fistulas and post-operative sutured end.

Figure 1: Fistulous tract noted at 2'0 clock position.

Figure 2: Ends sutured using 2-0 vicryl.

DISCUSSION

Acute fistulas resulting from obstetric and operative trauma often heal spontaneously within 6 to 12 weeks. The diagnosis is typically confirmed by physical examination, while endoscopy may be performed to rule out other causes. A low RVF is located between the lower one-third of the rectum and the lower half of the vagina, close to the anus, and is usually corrected via a perineal approach. In contrast, a high RVF is situated between the middle third of the rectum and the posterior vaginal fornix and is typically managed through a transabdominal approach.

The OASI care bundle emphasizes the importance of informing the woman about OASI and the steps to minimize the risk, including providing an information leaflet. Manual perineal protection should be used during spontaneous births, if the position permits (excluding water births), and for all assisted births using forceps or ventouse. When indicated, a mediolateral episiotomy at a 60-degree angle should be performed at crowning. After delivery, the perineum must be thoroughly examined, and any tears should be graded according to RCOG guidelines. This examination must include a per rectum check, even when the perineum appears intact.[3]

The increasing trend in OASI incidence is attributed to better awareness, improved reporting, and changes in obstetric practices. Surgical options for an established RVF include local repair via transanal, transvaginal, or transperineal routes; tissue transposition procedures such as gracilis muscle or labial fat grafts; and transabdominal repair, especially for high RVFs. For fistulas with an intact sphincter, a simple fistulectomy can be performed, which is particularly effective for anovaginal fistulas. In such cases, the edges of the anterior rectal wall are inverted during the procedure.[4]

CONCLUSION

The choice of surgical technique in the treatment of RVF remains difficult because of poor literature data and absence of consensus. Individualised surgical approaches, skilled pelvic floor repair and a multidisciplinary approach are crucial for successful outcome. This case underscores the need for careful planning and consideration of patient characteristics in the management of RVF, aiming to achieve optimal outcomes and patient well-being.

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