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Case Report

A rare case of rectovaginal fistula caused by coital injury in a patient of MRKH

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ABSTRACT

Rectovaginal fistula is defined as an epithelized communication between the rectum and vagina with involuntary escape of flatus and/or faeces into the vagina. Rectovaginal fistula is a very distressing problem for women. The successful management of this problem depends on the etiology, size and location of both fistula, as well as assessing the competence of the continence mechanism. It may be acquired and congenital, the most common causes are obstetrical injury. Coital injury is very rare cause of recto vaginal fistula. Here we are reporting a rare case of MRKH along with recto vaginal fistula resulting from coital trauma.

Keywords: Rectovaginal fistula, Mullerian agenesis

INTRODUCTION

Mullerian agenesis is a congenital malformation characterized by a failure of the Mullerian duct to develop, resulting in a missing uterus and variable malformations of the upper portion of the vagina. The condition is called Mayer-Rokitansky-Kuster-Hauser syndrome.[1] Rectovaginal fistula is defined as an epithelized communication between the rectum and vagina with involuntary escape of flatus and/or faeces into the vagina.[2]

It may be acquired and congenital, the most common causes are obstetrical injury. Coital injury is very rare cause of recto vaginal fistula. Here we are reporting a rare case of MRKH along with recto vaginal fistula resulting from coital trauma.

CASE REPORT

A 18 year nulliparous married girl present in gynaecology OPD with a complaints of:

- Primary amenorrhoea
- Passage of stools per vaginum for last 5 month.

The patient was married 6 month back and immediately after her first intercourse she noticed bleeding per vaginum which was assumed by the patient as menarche. After few days her bleeding stopped for which she never consulted any physician, after 1 month of this episode she experienced passage of stool and flatus per vaginum. Later, she got divorced by her husband when he came to know about her problem.

On examination, patient was female phenotype, her secondary sexual characteristics were well developed (tanner stage 5th). On local examination, on posterior vaginal wall there was a big hole of about 2 cm present just inner to fourchette upto the pouch of Douglas, there was merely a thin skin bridge below the fistula and vagina was also under-developed. On bimanual examination, the finding was confirmed and uterus and cervix were absent. On per rectal examination, same findings were confirmed. On sonography examination, there was absent left kidney with right kidney measuring

12 x 58 mm which was not visualized in the right renal fossa but visualized in pelvic cavity with absent uterus and cervix with both ovaries normal.

After routine preoperative preparation repair was done. During procedure, the thin skin bridge below the fistula was cut. Recto vaginal fistula was converted into complete perineal tear. Then repair was done exactly similar to repair of complete perineal tear. Post-operative period remained uneventful and she was discharged after 15th days of surgery in satisfactory condition. She had a follow- up after 6 month and was relieved all of her symptoms and was continent for stools & flatus.

Figure 1: Showing large rectovaginal fistula.

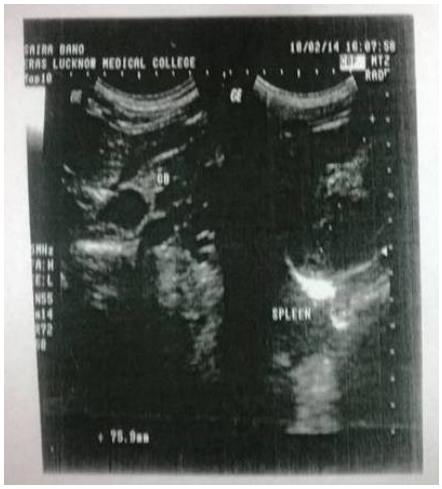

Figure 2: USG film of the patient.

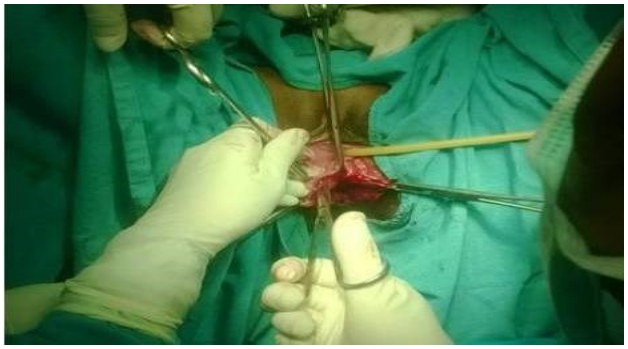

Figure 3: The surgical procedure.

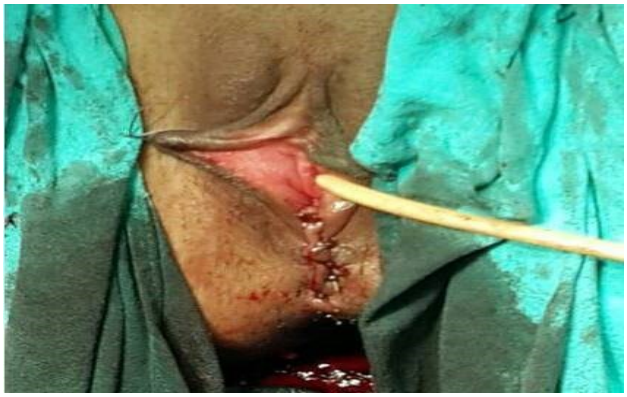

Figure 4: Immediately after surgery.

DISCUSSION

Uterine Mayer-Rokitansky-Kuster-Hauser (MRKH) Syndrome results from a failure of the Mullerian ducts to reach the urogenital sinus due to a disorder involving the ureterovaginal canal or the vaginal plate. It appears to be a sporadic polygenic multifactorial disorder occurring between 4th and 12th weeks of gestation[2] as no specific gene could be identified yet. The incidence is usually 1 in 4000 to 5000 live female birth.[3]

The patients are typically 46, XX female with normal secondary sex characters that commonly present at puberty with amenorrhoea as in our case. Most patients have both fallopian tubes and ovaries. They are also associated with anomalies of urinary tracts[4] which was present in our case.

The treatment MRKH syndrome depends upon the anatomy of the individual patients. The goal of therapy is to provide adequate sexual function and deal with the psychological impact that the patient has no uterus or vagina. Fertility is possible and is an option that should be offered to the patients because both the ovaries are usually normal and successful in vitro fertilization with surrogate pregnancy has been achieved.[5,6]

Shu Wang (2010) reviewed 133 cases of MRKH in 10-year span; three cases of uterovaginal agenesis concomitant with recto vestibular fistula and imperforate anus were reported.[7]

Mahajan JK (2009) described a MRKH syndrome with H type anovestibular fistula and cloacal malformation presented in early infancy. He also mentioned that anorectal malformations are uncommonly associated with MRKH syndrome.[8]

Shalika Jayaswal, Nitin Dhende, SB Mane reported similar case in 3 month old baby passing of stools from vagina on straining. Though the vaginoplasty was done in single stage, child had recession of neo anal opening which was further managed by reanoplasty and sigmoid colostomy.[9]

CONCLUSION

Rectovaginal fistula can be a distressing problem for women. The successful management of this problem depends on the etiology, size and location of both fistula, as well as assessing the continence mechanism. MRKH syndrome association with recto vaginal fistula is rare. The diagnosis as well as such cases remains challenge to the gynaecologist due to varied presentations, the case is unique as coital injury is very rare cause of recto vaginal fistula.

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