

Rectovaginal Fistula

A Guide for Women

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What is a rectovaginal fistula?

A rectovaginal fistula is an abnormal passage or opening between the rectum and vagina. Some women may be asymptomatic, but most complain of an uncontrollable passage of gas and/or stool through the vagina. This may be associated with rectal bleeding, foul-smelling discharge from the vagina, or recurrent vaginal infections. It is usually the incontinence of gas and stool that leads a woman to seek therapy. She may not know an abnormal tract is present between the rectum and vagina.

What causes a rectovaginal fistula?

The majority of rectovaginal fistulas are caused by childbirth injury. Trauma related to operative vaginal deliveries (e.g. forceps and vacuum deliveries) as well as third and fourth degree tears increase the risk of development of rectovaginal fistulas. Rectovaginal fistulas can also develop following radiation to the pelvis or in women with inflammatory bowel disease. There are rare cases of congenital rectovaginal fistulas usually associated with imperforate anus.

Risk factors for development of rectovaginal fistula include:

- Congenital anorectal anomalies
- Obstetric trauma
- Gynecologic or colorectal surgery
- Violent trauma
- Inflammatory bowel disease
- Perianal infections
- Radiation to pelvis
- Malignancy

How is a rectovaginal fistula assessed?

A discussion with your primary care doctor is the first step of the assessment. A review of your health history and recent surgeries will help your doctor suspect a possible rectovaginal fistula. A pelvic exam should be done to assess the perineum (area of skin between the vagina and anus). Applying rectal pressure during the exam may express stool into the vagina to see the fistula. A thin probe may also be used to identify the fistula.

Rectovaginal fistulas often may involve disruption to the internal and external anal sphincter muscles. Further testing may be done to help assess these muscles. This may involve anal manometry, which assesses the tone and contractility of these muscles. Endoanal ultrasound may also be used to look for dis-

ruption of the muscles. Further imaging studies like a CT scan or colonoscopy may be utilized to rule out fistula tracts involving the colon or small bowel. Other medical conditions should be ruled out including inflammatory bowel disease and cancer.

What are the treatment options?

Not all fistulas need surgical intervention. Often rectovaginal fistulas associated with inflammatory bowel disease close on their own without needing surgery. If diagnosed early after a traumatic event, direct closure may be considered. Most often rectovaginal fistula repairs are delayed until inflammation around the fistula subsides.

The surgical approach to rectovaginal fistulas may involve either a transvaginal or transanal repair. This depends on the surgeon's training and extent of the fistula. If the fistula is large a surgeon may consider a diverting colostomy to allow the tissue to heal. Closure of the colostomy is done once the fistula is healed. Irrespective of the approach, the fistula tract should be excised to allow normal tissue with a good blood supply to be brought together. Often the tissue near the fistula tract has poor blood supply and may need a graft to help promote healing. Grafts or flaps can include a woman's own fat tissue or muscle that is placed over the repaired fistula tract. Other biologic grafts taken from animal tissue or human cadavers can also be used. The repair may also involve reconstruction of the internal and external anal sphincter muscles.

The success rate following rectovaginal fistula repair is high, ranging from 90-95%. Patients with recurrent fistulas or a history of radiation may have a poorer prognosis.

Following rectovaginal fistula surgery women should watch their bowel habits with the goal of daily soft, formed stools. Avoiding constipation and diarrhea is important as this can cause disruption to the repair and increase the risk of wound infection.

For more information, visit www.YourPelvicFloor.org.