

Isolated Ano-vaginal Fistulae without Associated Vesicovaginal Fistulae Following Prolonged Labor: A Rare Entity

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ABSTRACT

Isolated ano-vaginal fistulae without associated vesicovaginal fistulae following prolonged labor have not been reported. They present with fecal discharge per vaginum. A two-layered fistulae closure with interposition flap is the treatment of choice. Herein, we report such a rare entity that deserves mention.

INTRODUCTION

Vesicovaginal fistula is the most common acquired genitourinary fistula following obstructed labor, but isolated ano-vaginal fistula following obstructed or prolonged labor has not been reported. Such fistula is very bothersome to the patient because of the fecal discharge per vagina. Herein, we report such a case of isolated ano-vaginal fistulae following prolonged labor. The fistula was closed in 2 layers with an interposition flap.

CASE REPORT

A 21-year-old primipara presented with a history of passing stools per vagina for 3 months. The patient started passing stools per vagina 1 week following labor. There were no voiding symptoms. The patient had a history of prolonged labor (36 hours) in which she delivered a live baby in a peripheral government hospital. There was no history of episiotomy or a forceps delivery. The fetus had cephalic presentation, but the baby expired 3 days following birth, and the cause of death was unknown. On speculum examination of the vagina, the patient was found to have an isolated, 1.5 cm x 1 cm wide ano-vaginal fistula, 1.5 cm from the vaginal introitus communicating with the anal canal (Figure 1a). The anal sphincter was intact. Cystoscopy ruled out concomitant vesicovaginal fistulae (VVF). The patient was initially managed by sigmoid colostomy. A distal loopogram 3 months following a colostomy showed the typical finding of ano-vaginal fistulae (Figure 1b). The patient

Figure 1a. A probe in the ano-vaginal fistula.



KEYWORDS: Ano-vaginal fistulae, vesicovaginal fistulae, obstetric delivery, interposition flap

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Figure 1b. Distal loopogram showing communication between the vagina and anal canal.



Figure 2a. After complete 2-layer closure of the ano-vaginal fistula with interposition of the Martius flap.



was managed by closure of the fistula through the vaginal approach. The closure was done in 2 layers with interposition of a Martius flap (Figure 2a). A repeat distal loopogram confirmed closure of the fistula (Figure 2b). Colostomy closure was done after 6 weeks of fistula closure. The vaginal discharge of feces stopped following fistula closure, and the patient is doing well in follow-up.

DISCUSSION

Ano-vaginal fistulae are abnormal epithelial-lined connections between the anal canal and vagina. The causes of ano-vaginal fistulae could be obstetric trauma, inflammatory bowel disease, anal surgeries, radiation, and trauma [1]. Prolonged labor with necrosis of the ano-vaginal septum or obstetric injury with a third- or fourth-degree perineal tear or episiotomy can lead

to ano-vaginal fistulae. Inadequate repair, breakdown of the repair, or infection of episiotomy can all result in fistulae development [2].

In our case, the cause of ano-vaginal fistulae could have been because of compression of the fetal head against the impacted feces or could be due to the rupture of a pre-existing, unrecognised anal abscess into the vagina that was superimposed upon prolonged, neglected labor. However the detailed history of the patient ruled out any perianal abscess.

The obstetric vesicovaginal fistulae in association or with rectovaginal fistulae have been reported [4,5]. Prolonged labor causing isolated ano-vaginal fistulae without concomitant VVF has not been reported in the literature. Based on the basic surgical principle of fistulae closure, the fistula was dissected and closed in 2 layers with interposition of the Martius flap similar to VVF repair [3]. Temporary colostomy may or may not be required in rectovaginal fistulae closure. The rectovaginal fistulae may be repaired concomitantly with VVF repair [5]. In

CASE REPORT

our case the approach of temporary colostomy and delayed closure of the fistula was followed.

CONCLUSION

Isolated ano-vaginal fistulae following prolonged labor is extremely rare and should be managed by fistulae closure in 2 layers and stages.

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Figure 2b. Repeat distal loopogram 6 weeks after fistula closure showed healing of the ano-vaginal fistula.

