Incont Pelvic Floor Dysfunct 2009; 3(1):22-23

Concomitant Anoplasty for Short Perineum and Rectovaginal Fistula during Urogenital Prolapse Repair

Ching-Chung Liang, M.D.

Department of Obstetrics and Gynecology, Chang Gung Memorial Hospital, Linkou Medical Center, Taoyuan, Taiwan; E-mail: ccjoliang@cgmh.org.tw

BRIEF HISTORY

A 48-year-old mother of 4, was referred to our hospital for further evaluation of a genital prolapse. She complained of a sensation of a vaginal mass and backache during strenuous work. She also presented with nocturia, dysuria and occasional stool passage from the vagina which had occurred for more than 10 years. Treatment at a local clinic had failed to solve the problem. Her medical history was unremarkable, except for severe perineal damage during her first vaginal delivery. Pelvic examination revealed a uterus of normal size, grade 3 cystocele, grade 2 rectocele, grade 3 cervical descent and a short perineal body (0.5 cm in length). Patient's pelvic organ position quantification (POPQ), a system used to assess the possibility of pelvic prolapse, were +3, +5, +5, 4.5, 0.5, 7, +1, +1 and 0. A recto-vaginal fistula was located over the distal vagina. The patient underwent a complete urogynecologic evaluation consisting of a one-hour perineal pad test, bladder diary and urodynamic study. No urine leakage was found during urodynamic testing.

After admittance, the patient asked for a hysterectomy and bladder suspension to resolve her genital prolapse. Regular check-ups are still being made.

SURGICAL TECHNIQUE

After spinal anesthesia was induced, the patient was placed in a dorsal lithotomy position and the labia were retracted with stay sutures. The bladder was initially catheterized and left free to drain. After the uterus was extirpated, closure of the abdominal peritoneum was performed. The uterosacral and cardinal ligaments were then tied to each other across the midline with 1-0 polyglactin, and sutured on either side of the vaginal cuff. Concomitant anterior and posterior colporrhaphy were performed for both the cystocele and rectocele.

The next operative procedure was anoplasty for rectovaginal reconstruction. Anoplasty is a surgical technique whereby perianal skin flaps are transported to reconstruct the perineal body [1]. It is also used to supplement the conventional repair of an obstetrical injury and fistula-in ano [1,2]. The principles of the repair included a cruciate incision across the perineal body (Fig. 1), dissection of the rectovaginal septum to separate the two structures, amputation of the fistula and redundant mucosa (Fig. 2), levator plication, external sphincter approximation (Fig. 3), and advancement of the skin flaps to establish a normal distance between the anus and the introitus (Fig. 4 and Fig. 5).

COMMENTS

Treatment of rectovaginal fistulas depends on their etiology and location. High rectovaginal fistulas are usually approached by laparotomy. For mid and low rectovaginal fistulas a number of operative approaches have been advocated: transvaginal, transperineal, transanal and transsacral. If a patient has an anovaginal fistula, she should be treated with a perineal operation [1,2].

REFERENCES

1. Corman ML, Veidenheimer MC, Coller JA: Anoplasty for anal stricture. Surg Clin North Am 1976; **56**:727-731.
2. Corman ML: Anal sphincter reconstruction. Surg Clin North Am 1980; **60**:457-463.

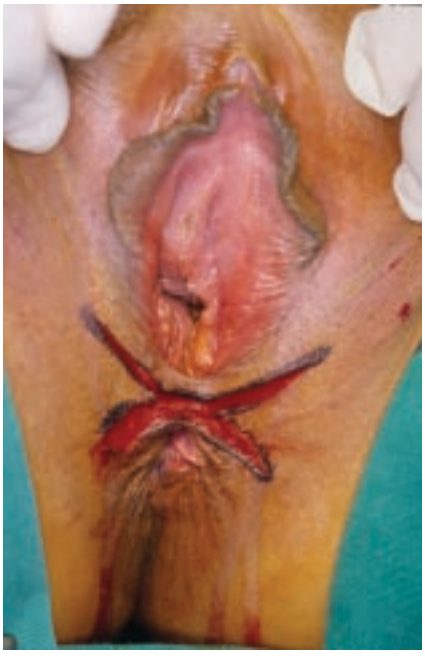

Fig. 1. A cruciate incision is made across the perineum.

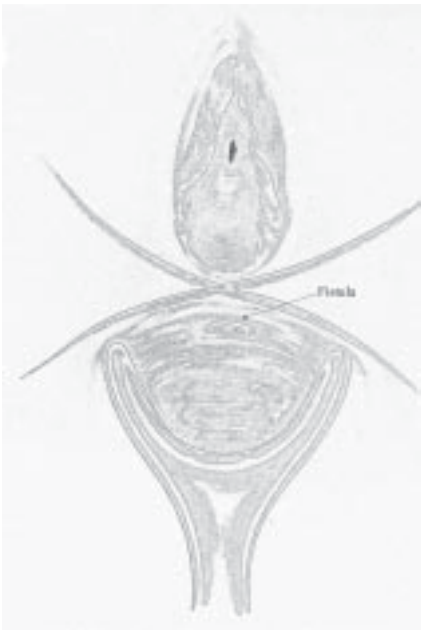

Fig. 2. A rectovaginal fistula is identified through the anal orifice.

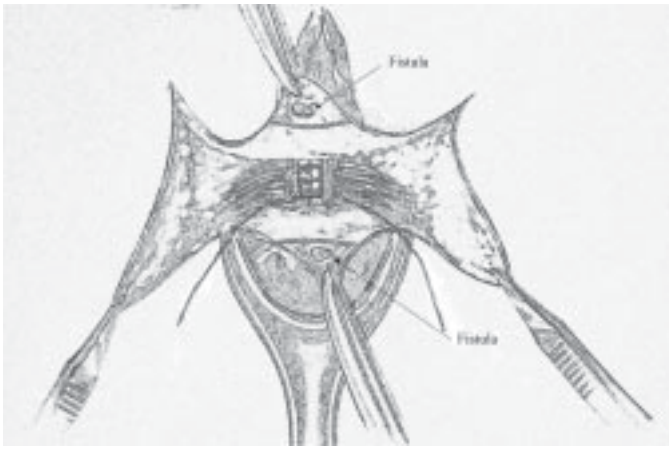

Fig. 3. The levator ani muscle is plicated. The redundant mucosa and fistula are excised. The external sphincter is approximated.

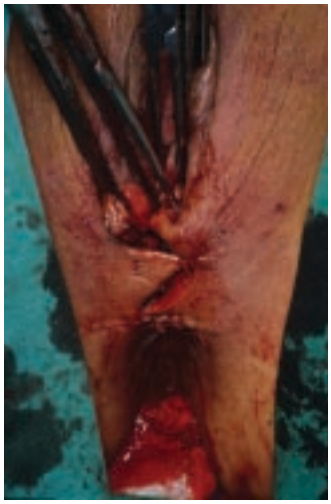

Fig. 4. The two triangular flaps are transported. The effect is to displace the rectum farther from the vagina.

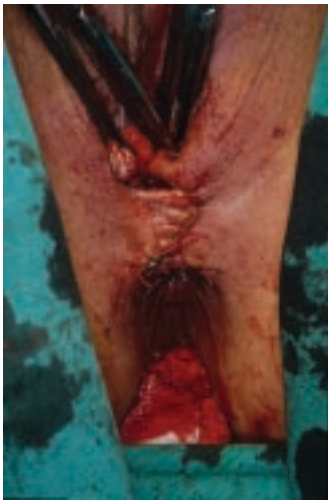

Fig. 5. Rectovaginal reconstruction completed by advancement of skin flaps. The distance between the anus and the vagina is normal.