

## 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. While some women may have no symptoms, 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 or urinary tract infections. It is usually the incontinence of gas and stool that leads a woman to seek treatment. She may not know an abnormal passage 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 such as forceps and vacuum deliveries, as well as third- and fourth-degree tears, increases the risk for rectovaginal fistulas to develop. 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.

Risk factors for development of rectovaginal fistula include:

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

#### How is a rectovaginal fistula assessed?

A discussion with your primary care doctor is the first step of the assessment. Your doctor will thoroughly review your medical, obstetric, and surgical histories as well as discuss your symptoms. A pelvic exam should be done to assess the perineum (area of skin between the vagina and anus). Applying rectal pressure during the exam assess the perineum, anus/rectum, and vagina. A thin probe may also be used to identify the fistula.

Rectovaginal fistulas may involve disruption to the internal and external anal sphincter muscles. Further testing may be done to help assess these muscles as well as confirm a fistula if one is not evident on examination. This may involve function of the rectal and anal muscles, which assesses the muscle tone and ability of these muscles to contract. Endoanal ultrasound may also be used to look for disruption of the muscles. Further imaging studies like a CT scan or colonoscopy may be utilized to rule out fistulas 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. Rectovaginal fistulas associated with inflammatory bowel disease may close on their own without surgery but should be managed with GI medicine or colorectal surgery. If diagnosed early after an inciting event, immediate 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 a repair either through the vagina (trans-vaginal) or through the anus/rectum (trans-anal/trans-rectal) repair. This depends on the surgeon's training and the position and size 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. A stoma (ileostomy or colostomy) is where part of the bowel is brought to the surface of the skin of the abdomen so that the waste material (stool) empties into an airtight bag rather than passing through the rectum; it diverts the flow of feces away from the site of the repair.

Irrespective of the approach, the fistula tract should be removed to allow normal tissue with a good blood supply to knit together. If the tissue near the fistula tract has poor blood supply, a graft or flap may be placed to promote healing. Grafts, or flaps, can come from 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.

Following rectovaginal fistula surgery, women should monitor their bowel habits with the goal of having daily bowel movements of soft, formed stool. Avoiding constipation and diarrhea is important as this can disrupt the repair and increase the risk of wound infection.

#### How successful is surgical repair of rectovaginal fistula?

The success rate for rectovaginal fistula repair is high, ranging from 90-95%. Patients with recurrent fistulas or a history of radiation may have a poorer outcome. Fecal incontinence, even with successful fistula repair, up to 30-40% of women may still experience fecal incontinence with leakage of stool or gas from the anus, especially if the fistula involved the anal muscles.

#### What if my rectovaginal fistula does not heal?

Some women are never 'cured' of their fistula, meaning it never fully closes. However, surgery often shrinks the fistula to such a small size that an acceptable outcome is reached, and further surgery is declined. Sometimes a surgical thread, called a seton, is placed through the fistula to help control drainage and again, symptoms are controlled such that no further surgery is required.

For more information, visit [www.YourPelvicFloor.org](http://www.YourPelvicFloor.org).