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Rectovaginal Fistula

A Guide for Women

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What is a rectovaginal fistula?
A rectovaginal fistula is an abnormal communication or tract 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 women to seek therapy and may not know an abnormal tract is present between vagina and rectum.

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 3rd and 4th degree tears increase 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?
An initial discussion with your doctor, who reviews your health history and recent surgeries, can help him/her suspect a possible genitourinary fistula tract, though most women complain of passage of gas or stool through the vagina.

Initially, a pelvic exam should be done to assess the perineum (area of skin between vagina and anus), as well as the anus and rectum. A rectal exam may help isolate the fistula tract and applying pressure during the exam may express stool into the vagina to see the tract. A thin probe may also be used to identify the fistula tract.

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 and can assess for weakness. Endoanal ultrasound may also be used to look for disruption of the muscles or whether the fistula tract involves these muscles. It can also be used to further evaluate location of the rectovaginal fistula. 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 with medical management. If diagnosed right after traumatic event, direct closure may be considered, though most often rectovaginal fistula repairs are delayed to allow inflammatory tissue around fistula tract to resolve.

The surgical approach to rectovaginal fistulas may involve either a transvaginal or transanal repair. This depends on the surgeon's training and extent of fistula. If the fistula is large a surgeon may consider a diverting colostomy to allow the tissue to heal following the repair and then close the colostomy once the fistula is healed. No matter the approach the fistula tract should be excised to allow normal tissue with a good blood supply to be brought together. Often times the tissue near the fistula tract has poor blood supply and may need a graft to help promote healing near fistula tract. 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%, though patients with recurrent fistulas or 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 risk of wound infection.

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