

Complications and Surgical Management of Colovaginal or Enterovaginal Fistula after Simple Hysterectomy

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1. Introduction

A vagina fistula is a tunnel-like opening that develops in the wall of the vaginal. The vagina is the muscular tube between vulva and cervix, the mouth of the uterus. The vaginal fistula opens between the vagina and an organ in the urinary system or digestive system. Damage to tissue in the vagina wall causes a hole to form where it doesn't belong to. For example, it can cause bleeding into the digestive system or it can cause the stool to be evacuated through the vagina, which causes major discomfort for the woman in every day but also in intimacy. There can be also a case of genitourinary vaginal fistulas for between the vagina and uterus and organs in the urinary system (1).

2. Summary

2.1. Other Types of Vaginal Fistulas

Rectovaginal fistula – occurs mainly after natural delivery where there is damage of perineum and vagina, especially as iatrogenous complication on rectum or vagina. Practically knowledge also shows home-treatment of some patients who are afraid to go to a gynaecologist, so they apply e.g. Garlic inside of vagina or before birth they use so called anni-ball to stretch the vagina to the side of the head of newborn, not realizing tearing tissue which is still hormonally not ready.

Spontaneous colovaginal fistulas can occur in anatomically disposition of long dolichosigma which is able to drop down to pelvic

bottom and occur either in inflammatory-perforation conditions, such as carcinoma of sigma perforans or diverticulitis perforans.

Another because which is much more often is being beginning of fistulation of non-adequate hemostasis after hysterectomy or conglomeration of hemoragic fluid on the vaginal stump, with insufficient drainage after surgery. The most common reason in gynecology surgeries – hysterectomy- is insufficient peritonealisation of pelvic bottom, which causes granulation between enteric loop and vaginal stump (2). All these fistulas can be either continual or intermittent, and therefore the most important in diagnostics is to differentiate between enteric or colic fistula. The most common diagnostics is using contrast peroral substance in cases of enteral fistulas, or per rectal applied contrast substance in cases of colic fistulas. This is all done under CT or RTG control. Not in all cases is this diagnostics precise, therefore classical physical examination to determine vaginal orificium. Sometimes is useful to do deep vaginal tamponade and per rectum apply concentrated Betadine solution and control colour changes on the tamponade.

3. Surgical Treatment

It is very simple, whether it comes to enteric or colic fistula, and that is to remove this fistula by partial resection and suturing the fistula stump. The major aspect to avoid such complication or its recurrency is precise peritonealisation of pelvic bottom if possible, and if not, in those cases is useful closing the pelvic bottom by omentoplasty or Bifacial mesh (Figures 1-2).

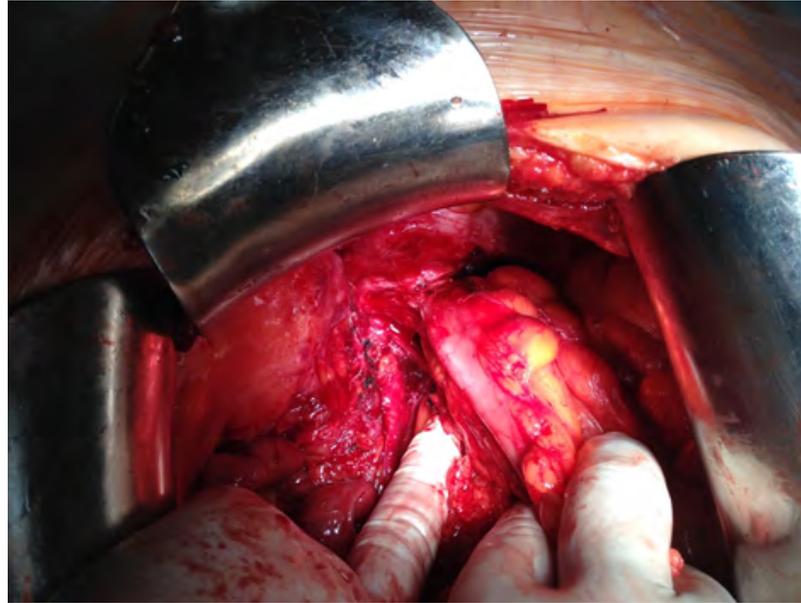


Figure 1: Perioperative Finding

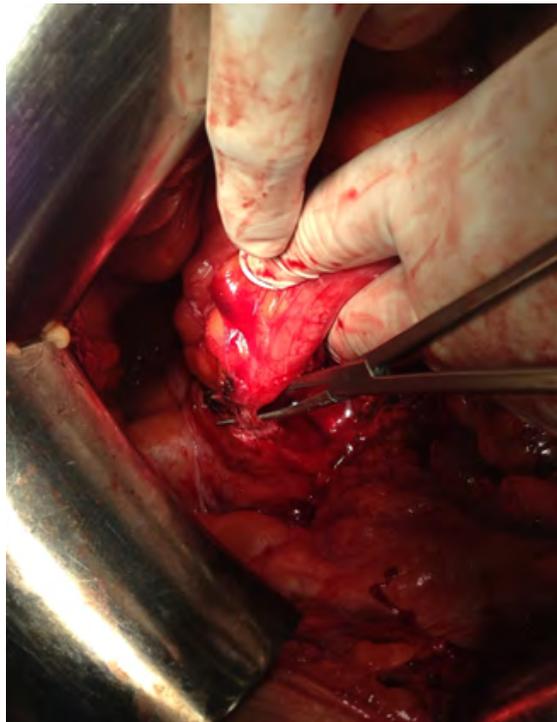


Figure 2: Preparation of the Fistula

4. Discussion

The most common mistake is estimated around 5 out of 100 post-operative fistulas. It decreases intimate and every day quality of life, but because of the shame of the patients, most of these cases stay untreated. There should be cautious not to be shamed in case of bigger blood losses to drain and leave drainage for 24-48 hours to see the status of the patient in real time. Because complications can be making of hematoma and abscessus of pelvic bottom, dehiscence of vaginal stump, either with prolaps of enteral loops through vagina and in complete dehiscence the case of fistulation.

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