4.1 Introduction

Rectovaginal fistulae (RVF) may be considered as “border-line” disease, in that they may be managed by the gynecologist, colorectal surgeon, or, more rarely, by the general surgeon. RVF may be iatrogenic, as they may occur following surgical procedures, such as anterior resection of the rectum, Delorme mucosectomy, stapled transanal rectal resection (STARR), Altemeier perineal proctosigmoidectomy, Transanal Endoscopic Microsurgery (TEM), or rectocele repair. Rex and Khubchandani (1992), in a survey carried out among members of the American Society of Colon and Rectal Surgeons, found that 3.5% of anterior resections (7% when including female patients) were followed by RVF.

However, most RVF, those with the best prognosis after surgical repair, are post-obstetric (Fig. 4.1). According to Rothenberger (1993), RVF may be classified into two categories: 1) simple RVF, which are low, small, and involve a healthy rectum, and 2) complex RVF, which are high, larger than 2.5 cm, and involve a diseased rectum (usually in patients with Crohn’s disease or who have received radiotherapy) and/or are recurrent after failed surgical repair. Complex RVF, which may require an abdominal procedure that includes rectal resection and coloanal anastomosis, are more likely to be followed by postoperative complications and recurrences. By contrast, simple RVF are usually managed by a transanal, transvaginal, or perineal route.

Fig. 4.1 a The patient came to our observation with a diverting colostomy. She is in the lithotomy position. A low rectovaginal fistula is observed.

Fig. 4.1 b Low transvaginal incision and removal of the vaginal tract of the fistula.
4.2 Types of Operations and Postoperative Complications

The types of surgical procedures and the most frequent postoperative complications are listed in Table 4.1.

I have personal experience with nine of these procedures. I used graciloplasty just once, in a patient with an ileal pouch-vaginal fistula after restorative proctocolectomy. I have never performed Schouten’s trans-sacral operation but I did carry out a lay-open procedure in a patient with Crohn’s disease, who fortunately remained continent. I have also never performed gluteoplasty, bulbo-cavernous muscle interposition, or plug procedures. Most of my patients (Gagliardi and Pescatori, 2007) have been treated with an episiotomy with layered closure, puborectalis muscle interposition, fistulectomy with rectal advanced flap through the anus, and an inversion and layered closure through the vagina. I was taught these four types of surgery by