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Consensual Postcoital Rectovaginal Fistula

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Abstract

Consenting sexual intercourse (CSI) leading to rectovaginal fistula (RVF) is a rare event. However, its incidence is on the rise. It is a distressing, uncomfortable and devastating condition in women. Failure to identify can lead to delayed treatment and poor outcome. Clinicians need to be aware of such injuries. The index case of acute RVF following CSI is being reported to highlight its unusualness, and management in an emergency setting. A 32-year-old lady was admitted for severe abdominal pain, bleeding per vaginum, release of flatus and fecal matter through the vagina following consensual vaginal intercourse (CVI) in the emergency department. A diverting colostomy was performed. RVF was repaired transvaginally, she became continent to both feces and flatus and colostomy was closed.

Keywords: Rectovaginal fistula; Colostomy; Consensual intercourse

Introduction

A rectovaginal fistula (RVF) is an abnormal communication between the rectum and vagina. They are rare and majorities are of traumatic origin (obstetric/surgical incidents) [1]. It is an embarrassing condition for the woman both physically and mentally. Coital trauma mostly occurs in the context of sexual violence, abuse or rape. RVF following consenting sexual intercourse (CSI) is exceptional. It may be due to woman's virginity, vaginismus, Mullerian anomaly or genital malformation, the disproportion in size between the penis and vagina, or by vaginal dryness or repeated aggressive act [1]. Treatment depends on the cause, location, size, number, types, seriousness of symptoms, the condition of the tissues around the fistula, any associated problem that needs to be taken care of, the age and general condition of the individual.

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Case Report

A 32-year-old young lady presented to the emergency, with severe abdominal pain, bleeding per vaginum, passage of flatus and fecal matter through the vagina. She had CVI a day before reporting to the hospital. The above symptoms started immediately after the painful and aggressive sexual act. She had heavy bleeding which stopped after 24 h but she started passing flatus and fecal matter through the vaginal route. Due to embarrassment, she did not report immediately to the hospital. However, her previous sexual experiences with the same partner were uneventful. This time she experienced severe pain during penetration and was lying in dorsal recumbent position. After admission, a diverting colostomy was performed. After 1 month of colostomy, she presented to us for second opinion and further management. Rectovaginal examination revealed a communication between the rectum and vagina (RVF). The fistula was 1.5 × 2.0 cm and was located 1.5 cm above the hymeneal ring. Its margins were indurated, fecal matter was seen coming through the fistula and was associated with foul smelling discharge. Anal sphincters and perineum were intact. The uterus was of normal size, and speculum examination revealed healthy looking cervix. A diagnosis of low RVF was made. She was trained in management of colostomy and perineal care. We waited till fecal matter stopped coming, induration subsided and discharge cleared. After 8 weeks, she was evaluated and was found fit for surgery. Patient was put on fluid diet for 24 h, and bowel preparation was done, followed by an overnight fasting for 8 h.

Transvaginal approach

The patient was positioned in the lithotomy position. The fistula and its tract were identified. A circumscribing incision was made around the edge of the fistula on the posterior vaginal wall. The edge of the fistula was trimmed, vaginal mucosa mo-

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bilized from the rectum and repair was done in three layers with vicryl #3-0 (rectal mucosa was closed by interrupted, seromuscular by continuous and vagina by continuous sutures). Our patient became continent of flatus and faeces and had an uneventful recovery. After 6 weeks, both vagina and rectum healed completely. After 8 weeks of repair, colostomy was closed. She has been followed up for 2 years to observe complete healing and to ensure absence of chronic fistula formation.

Discussion

Sex is a basic human need, consensual vaginal sex does occur and there is a rise in its want in recent times. Coital trauma mostly occurs in context of sexual violence/rape. Consensual vaginal sex normally does not give rise to any significant abnormality except for minor hymeneal/vaginal tears sustained during vaginal sex for the first time [2]. However, few cases of RVF have been reported following CVI [3] in unmarried/newly married [4], first coital act in a married woman/married with children with their husbands [2]. Symeonidis et al [5] reported extensive rectovaginal tear following consensual intercourse, a very rare occurrence. Recently more cases of RVF are being reported following CVI either due to increase in consensual sex due to change in life style, stress and strain of life, consenting sex being considered physiological and awareness. In our case, the aggressive sexual act and no fore play/change in position during sex could be a factor, because the previous sexual acts with the same partner were uneventful. Several surgical techniques can be used for the repair depending upon the type of the fistula. In our case, the fistula could have been repaired transvaginally at the first instance. Decision to perform colostomy and diversion of feces in the repair of such injuries should be taken judiciously [3]. Transvaginal repair for low RVFs has been reported with good success rate [1]. We have also had good success following transvaginal approach for obstetric fistulae (unpublished). Levatorplasty may be performed simultaneously. This requires lateral dissection. Closure of the levator muscle allows tissue to be interposed between the rectal and vaginal repair which in turn adds strength to the repair. We did not use this technique. However, we have used levatorplasty in cases where the fistula was big (unpublished). Initially our patient denied the history of consensual sex. However, gentleness, privacy, empathy and friendly approach are essential in these cases. The fistula healed, and colostomy closed but psychological suffering and the agony of severe pain, RVF, multiple admissions to the hospital, colostomy and repair of RVF still haunt her. She was counselled and reassured for her concerns, about future sexual incidents and impact of colostomy/RVF on fertility and delivery.

Conclusion

RVF following CSI is a rare, devastating event. These women need to be seen by a senior gynecologist/surgeon in an emergency setting. A detailed sexual history/clinical examination provides clue to the etiology. Timely diagnosis and management result in optimum outcome. However, these individuals require counselling and psychological support to prevent negative impact on their future sexual functioning.

Conflict of Interest

The authors declare no conflicts of interest.

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