Case Report

Caecovaginal fistula following hysterectomy—a case report

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ABSTRACT

Colonic fistulas are usually complications of surgery, either colonic, pelvic or other abdominal surgeries. Other aetiologies like diverticular disease, crohn’s disease, pelvic irradiation and pelvic abscess have been implicated. We came across a patient with caecovaginal fistula following hysterectomy who presented with faecal discharge per vaginum. Laparotomy and excision of the fistulous tract was done. Although, fistulas are reported frequently in sigmoid colon, rest of the colon can be involved. But there is no reported case of caecovaginal fistula, even after thorough Internet search of Pubmed.

Key words: Caecovaginal, caecum, fistula, vagina

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Colonic fistulas are uncommon. They are frequently external but also occur internally to variety of organs. Although, they can be caused by Crohn’s disease or malignancy of colon, most of them are complications of a surgical procedure. Colovaginal fistulas present with vaginal discharge which may be faeculant. In this article, we report a case of a fistula between caecum and vagina following abdominal hysterectomy. Patient presented with faeculant vaginal discharge. Colovaginal fistulas tend not to close spontaneously or with medical treatment. The most common modality is usually a one-stage segmental resection of involved colon and primary anastomosis in a well-prepared bowel. Barium enema showed fistulous tract between the vaginal vault and the caecum. Laparotomy and excision of the tract was performed.

CASE REPORT

Forty-year-old female presently to us with discharge per vaginum since 2 years. It was semi-solid, foul smelling, faeculant and was copious in quantity. She was passing more faeces through vagina than via anus. It was associated with vague abdominal pain. She had history of undergoing hysterectomy 2 years ago for dysfunctional uterine bleeding (DUB). The vaginal discharge started one month after the surgery, and was minimal initially. It gradually increased and remains so for last 2 years. On examination patient was a well-built middle-aged female. There was faecal matter present at vaginal orifice. Speculum examination revealed fistulous opening. Patient was investigated and Barium Enema showed that caecum was pushed towards the vagina and a fistulous tract between caecum and vagina was present. Patient was posted for laparotomy electively. On exploration, caecum which was adherent to the vaginal vault was identified. Fistulous tract of 4–5 cm long and 2 cm in thickness was found between the caecum and vault of the vagina. Fistula tract was excised and the defect in the caecal wall and the vaginal vault was repaired. Postoperative period was uneventful. During follow-up check up, there was no discharge per vaginum.

DISCUSSION

Colonic fistulas are uncommon. They are frequently external but also occur internally to variety of organs. Colonic fistulas invariably are caused by a complica-
tion or as a result of a surgical procedure. Less commonly, they are caused by Crohn’s disease or malignancy of colon. Sigmoid colon is most commonly affected part, although other parts of the colon may be involved.[1]

There are many aetiologies colovaginal fistula, the most commonly reported aetiology is diverticular disease. They can also occur as a result of irradiation, pelvic surgery, malignancy, abdominal hysterectomy, abscess formation, perforation by foreign body, inflammatory bowel disease and trauma.[2]

Most patients with colovaginal fistula secondary to diverticular disease have undergone pelvic surgery especially hysterectomy.[4] Diverticular disease itself occur more frequently in sigmoid colon, which is relatively more mobile than the rest of the large bowel and therefore more likely to become adherent to vaginal wall.[3] A hysterectomy has been performed in 19 of 23 (83%) of the patients in a study by Woods et al.[5]

Colovaginal fistulas present with vaginal discharge. The volume and character of the discharge vary considerably. The volume may range from stain to profuse.[1] Most patients present with an abnormal discharge, which may not be recognized as frank faeces. Colovaginal fistulas may also present as vaginal flatus. There may be difficulty in obtaining the history especially in elderly. The discharge via the vagina can cause excoriation and increased sensitivity. The patient may present with bloody discharge from the colovaginal fistula.[3]

The patient in our report presented to us with vaginal discharge of faecal matter of moderate quantity, having history of hysterectomy 2 years back. There was fistula between caecum and vaginal vault diagnosed on barium enema and confirmed and repaired by laparotomy. In spite of a thorough Internet search of Pubmed there was no reported case of Caecovaginal fistula, although many reports of colovaginal fistula was found.

A good history in most cases will give an indication of presence of colovaginal fistulas and may point to aetiology. Pelvic examination with a speculum may reveal an opening or granular area at the apex of vagina that appear red.[1] A barium enema or enema using a water-soluble contrast material is not a reliable study to demonstrate fistula tract. A CT scan with contrast may in some instances demonstrate the tract.[1]

Vaginography is a technique that may be used to demonstrate the fistula tract. The patient is given enemas before procedure, Foley catheter with 30 ml balloon inserted in vagina and inflated with water. Meglumine Diatrizoate is used to fill vagina under gravity and fistula is easily visualized under fluoroscopic control.[6] Fistulogram with 50 ml gastrografin may be used to diagnose fistulas.[1]

Colovaginal fistulas tend not to close spontaneously or with medical treatment. The most common modality is usually a one-stage segmental resection of involved colon and primary anastomosis in a well-prepared bowel.[3] The vaginal defect may be closed with an absorbable suture or left open to granulate by secondary intention. A three-stage procedure would involve removing affected bowel, placing a colostomy and returning later to perform an anastamosis, with a protecting ileostomy or colostomy. It is rare these days. Emergency treatment of colovaginal fistula is not usually necessary.[3]

In this article, we have reported a case of caecovaginal fistula following hysterectomy. This is a rare case because of the involvement of caecum. Although, colonic fistulas are common, there are no reported cases of caecovaginal fistula.

REFERENCES