Rectovaginal Fistulas and Pelvic Abscess after Resection of Rectovaginal Endometriosis

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INTRODUCTION

Three women with endometriosis infiltrating into the middle third and possibly into the lower half of the vagina had bowel resection and anastomosis in 1997 and 1998. Although these 3 women had been classified as having involvement of the rectovaginal septum (Adamyan Retrocervical Stage IV), this is to the level of the septum but not into the area of the septum. Bowel resection and anastomosis was complicated by rectovaginal fistula in 2 women and perirectal abscess in the third. Both of the women who preserved their uterus had rectovaginal fistulas.

OBJECTIVE

The purpose of this poster is to present rectovaginal fistulas, perirectal abscess, lack of bladder sensation and persistent urge incontinence occurring in three women following segmental bowel resection with recto-sigmoid anastomosis for endometriosis infiltrating behind the middle third of the vagina.

MATERIALS AND METHODS

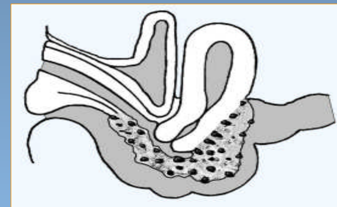
The charts of three women who had recto-sigmoid anastomosis for endometriosis infiltrating behind the middle third of the vagina were reviewed for findings on exam, intra-operative procedures, postoperative findings and ongoing care. All three women were contacted by phone in April of 2004.

These three women are part of a larger series of 114 women seen with bowel or vaginal endometriosis from 1997 to 2004. A fourth woman with endometriosis behind the middle third of the vagina had resection of unilateral endometriosis with superficial bowel involvement and repair. A fifth woman is avoiding surgery at present. The other 109 women had involvement no deeper than the upper third of the vagina. There was one bowel perforation among those other 109 women. There are no new cases of extension to this level since 1998.

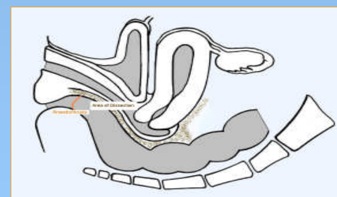
Institutional Board approval was not requested as these women were seen in the routine practice.

RESULTS

Three women had rectovaginal endometriosis diagnosed four to eight years prior to the surgeries presented on this poster. The leading edge of the endometriotic nodule was four to six centimeters from the hymen and/or anus on preoperative examination. All three women had severe pain and tenderness that interfered with their daily life. Preoperative consent included the possibility of colostomy. All three were bowel prepped and had seen a general surgeon prior to surgery.

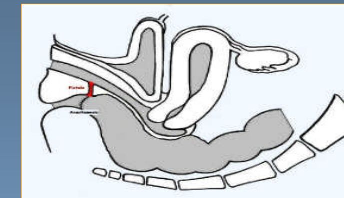


Recto-sigmoid anastomosis was performed in these three cases after segmental bowel resection. The anastomotic line was retrospectively estimated to be at three to four centimeters from the anus based on the site of the fistula in two women.



Rectovaginal fistulas occurred on post-operative days 14 and 15 in two women. Hospitalization for an abscess was on day 12 in a third woman.

RESULTS CONTINUED



All three women were contacted in April of 2004 and all three were in good health. The two with an intact uterus had delivered healthy infants at 15 months and 49 months after the original surgery. One patient had no sensation of bladder fullness for the first 2 ½ years and has persistent urge incontinence.

SUMMARY

These three women had endometriosis extending into the middle third of the vagina in the anatomic area of the Pouch of Douglas. One or more had rectovaginal fistula, perirectal abscess, lack of bladder sensation and/or persistent urge incontinence following segmental bowel resection and anastomosis. These complications were associated with a four or more year delay in resection. The two fistulas were associated with preservation of the uterus.

CONCLUSIONS

There were significant complications in these three women after surgery for endometriosis extending to the middle third of the vagina. No new cases have been noted at this level since 1998. Earlier resection and/or hysterectomy might decrease the chance of these complications in some women.

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