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Case Report

Conservative management of rectovestibular fistula in a pregnant woman

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Abstract

Rectovestibular fistula is a rare variant of anorectal malformations. Such malformations are commonly operated in newborn period or puberty. So it is so uncommon to coincide with uncorrected rectovestibular fistula in women of reproductive ages. Herein, we report a case of multigravida pregnant woman with uncorrected rectovestibular fistula. The patient's first pregnancy ended up by cesarean section at the second stage of labor after the realization of anorectal malformation. Despite the improvements in anorectal malformation managements, the patient survived without any reconstructive surgery and underwent successful pregnancy intervals in her first and present pregnancies.

Key words:

Rectovestibular fistula, anal atresia, pregnancy

Introduction

The incidence of anorectal malformations in the newborn is 1/5000 [1]. Rectal atresia is a rare variant of such anorectal malformations. It is predominantly seen in males with an incidence of 1-2% of all anorectal anomalies [2]. In rectal atresia, rectum opens to vestibule, urinary bladder or vagina with a fistula. Management options described in the literature have included perineal repair, vestibuloanal pull-through, anterior perineal anorectoplasty, and a limited or formal posterior sagittal anorectoplasty [3]. An extremely rare type of this abnormality, such as the presence of rectal atresia in a female with associated rectovestibular fistula has been reported [4]. In this case report, we present a multigravid pregnant woman with uncorrected rectovestibular fistula. To the best of our knowledge, this is the first pregnant case in the literature having rectal atresia with uncorrected rectovestibular fistula. Successful pregnancy intervals might lead to new counselling opportunities like conservative management for the patients having anorectal malformations.

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Case presentation

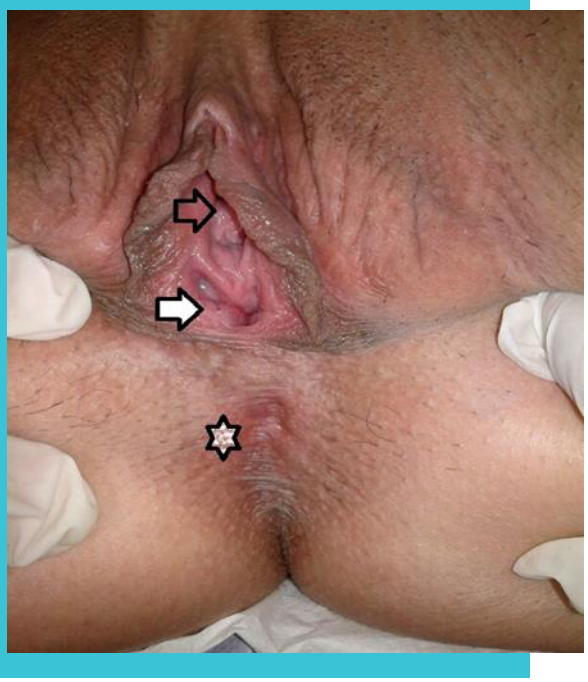
Twenty-four years old G2P1 woman admitted to our outpatient clinic with a delay in menses. An intrauterine single fetus at 8th gestational week with positive fetal cardiac activity was detected by ultrasonography (USG). Medical history revealed that the patient underwent cesarean section due to rectovestibular fistula at the second stage of labor in her first pregnancy. Pelvic examination revealed that the anus was not in the right place and the anal canal was opening into vestibule of vagina between the minor labium and vaginal mucosa (Figure 1 and 2). Urethra and the external genitalia were normal. Her defecation was performed via rectovestibular fistula into vestibule of vagina since the beginning of her life. She had difficulty in her first coital

experience and she still encounters problems in sexual intercourse since vaginal and rectovestibular fistula openings are too close. She had no any other complaints such as fecal incontinence or recurrent vaginal or pelvic infections.

Discussion

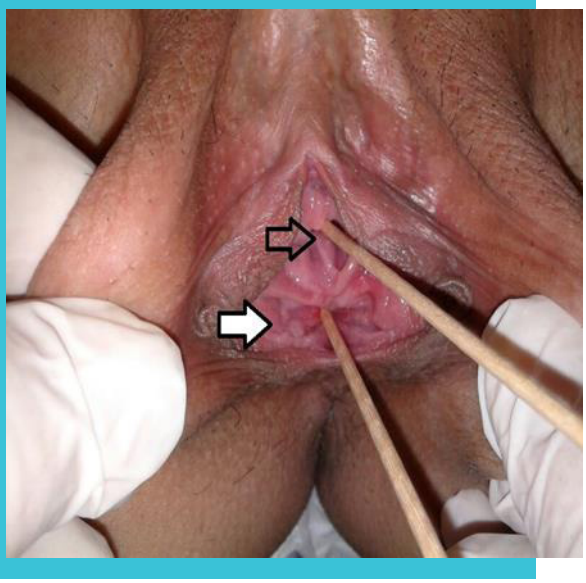
Incidence of such an anorectal malformation is 1/5000. The etiology of anorectal malformations is not clearly identified but it is thought to be multifactorial. Anorectal malformations can be corrected with convenient surgical procedures in the newborn period. Due to its rarity, there is no consensus on preoperative management, surgical technique and postoperative care. Management options for correction of rectovestibular fistula type anorectal malformations have included perineal repair, vestibuloanal pull-through, anterior perineal anorectoplasty, and a limited or formal posterior sagittal anorectoplasty [3]. The patient has been diagnosed with rectovestibular fistula in the newborn period but her parents opted against surgery. Based on a previous case, the authors reported a rare variety of anorectal malformation, rectal atresia associated with rectovestibular fistula which was successfully managed by posterior sagittal repair [5].

Figure 1.



Black arrow represents vaginal orifice and the white arrow represents rectovestibular fistula. The star also represents the indentation of the atretic anal canal.

Figure 2.



The upper pipe is in the vagina, the lower pipe is in the rectovestibular fistula.

Rectovestibular fistula may be accompanied with other congenital abnormalities, mostly related with gastrointestinale (36%), urogenitale (24%) and cardiovascular (16%) systems [6]. The patient was not diagnosed with any other accompanying body system abnormalities till now. She was in favor of surgery during her pubescence but she refused to undergo surgery due to risk of anal incontinence. In a retrospective cohort study, seventeen women with untreated or inadequately treated rectovestibular or rectoperineal fistulas were examined. All patients underwent by a posterior sagittal repair and major complaints at time of diagnosis were fecal incontinence, and concerns for hygiene and cosmetic [7]. The patient that we reported had difficulty in her first coital experience and she still has difficulty in sexual intercourse since vaginal and rectovestibular fistula openings are too close. She had no any other complaints such as fecal incontinence or hygiene problems. She had underwent cesarean section in the second stage of labor in her first pregnancy. Nowadays she has a healthy 20 weeks of pregnancy. In conclusion, congenital rectovestibular fistulas are a rare

form of anorectal malformations. To the best of our knowledge this is the first case presentation in the literature describing pregnancy in a woman with uncorrected vestibular fistula. This clinical entity needs further investigations for better understanding and comparing the pregnancy outcomes in patients with corrected or uncorrected rectovestibular fistula.

Conflict of Interest
Authors declare no conflict of interest

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