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Case Report

COITAL TRAUMA A CAUSE FOR RECTOVAGINAL FISTULA: A CASE REPORT

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ABSTRACT
Most cases of rectovaginal fistula are caused by obstetric injuries, surgical complications, malignancies and infections. Rarely it can occur following coitus. Usually ractovaginal fistula, resulting from coital injuries are reported late due to embarrassment. We report a case of post coital rectovaginal fistula which was reported after one year.

Keywords: *Rectovaginal Fistula, Coital Injury, Transvaginal Repair*

INTRODUCTION
Rectovaginal fistula (RVF) is an abnormal connection between the rectum and vagina allowing gas or stool to pass through vagina (Teresa and Jaime, 2010). They can be quite worrying to the patient due to their irritating and embarrassing symptoms and may cause emotional distress and physical discomfort. Trauma especially obstetric, malignancies, social injuries, inflammatory bowel disease or neurological problems causing pelvic floor denervation are the causative factors for rectovaginal fistula. Penetrating or blunt trauma and forceful coitus have also resulted in RVF. We report a case of rectovaginal fistula following coital injuries.

CASES
A 25-year old nulliparous woman, with low socioeconomic level presented to the OPD of Department of Obstetrics and Gynaecology, with complaint of foul smelling vaginal discharge since 1year followed by leakage of stool through the vagina for 8 months. Her complaint started 1 month after her marriage, when she noticed foul smelling discharge through the vagina. Initially it was intermittent, of faecal odour, used to increase with diarrhoea, relieved with constipation. Her first sexual relationship was forceful, associated with pain and vaginal bleeding for which she took treatment from local practitioner but not relived. She didn't consult any other doctor because of embarrassment. The problem gradually increased from passage of faecal odour discharge to faeces intermittently since 8 months. Now she attended hospital as there is passage of formed stool passing per vaginum with every act of defaecation.
General examination was unremarkable. Her pulse rate was 80 beats per minute and blood pressure was 110/70 mmHg. The chest and abdominal examination were normal. On local examination excoriation of skin and redness was present on external genitalia with perineal soiling by faeces. On per speculum examination a 3x3 cm large mid vaginal tear was present in posterior vaginal wall communicating with rectum. Margins were smooth with area of fibrosis around the defect. Rest of the vaginal mucosa was normal.
A rectovaginal examination confirms the presence of large mid vaginal fistula on the posterior vaginal wall about 2 cm away from the perineal body. She was investigated, counselled and consent was taken for repair of the fistula. Surgeon's opinion was also taken for need of colostomy before primary repair. She was placed on low residue diet and injection metronidazole 500 mg 8 hourly for two days and 24 hrs before procedure gut preparation done with Preglac solution and kept nothing by mouth 8 hrs before surgery. She was operated under spinal Anaesthesia. She had transvaginal repair in which circular incision was given around fistulous opening traction applied on the vaginal mucosa and counter traction on fistulous opening, vagina separated from rectum circumferentially. Fistulous tract excised. Non dominant finger put inside rectum and initial sutures were taken extramucosally 5-8 mm above and below

the fistulous tract including muscular is and submucosa with 3-0 delayed absorbable suture. Second layer of suturing done by inverting the initial suture line into rectum. In third layer, puborectalis and external anal sphincter approximated with 1 delayed absorbable suture. Lastly, vagina approximated with 3-0 delayed absorbable suture.

She was given clear liquid diet for 5 days and then on low residue diet and stool softeners. She made uneventful recovery with passage of stool through anal orifice with no evidence of faecal incontinence, and discharged on the tenth day. She was reviewed six weeks later. There was complete healing.

DISCUSSION

Non obstetric vaginal lacerations differ significantly from lacerations sustained during child birth. Vaginal injuries following coitus are quite frequent compared to rectal injuries and are usually mild and do not require medical intervention (Ijaiya *et al.,* 2009; Hembah-Hilekaan and Pam, 2011). Due to under reporting of the coital injuries true incidence is difficult to ascertain (Umoru *et al.,* 2003). It was reported to be 0.34% in Maiduguri (Omo-Aghoja *et al.,* 2009) and 0.7/100 of gynaecological emergencies in Abkara and Calabar (Abasiattai *et al.,* 2005; Kriplani *et al.,* 2007).

Vaginal vault and posterior fornix are the commonest sites for coital injuries, but other part of the vagina i.e. right fornix, left fornix and lower part of the vagina may be involved. Occasionally, it affects the posterior wall and may extends to the rectum causing rectovaginal fistula with flatus &/or faecal incontinence.

Etiologic and predisposing factors that are responsible for such injuries are virginity, low levels of education, non consensual and premarital sex with little or no foreplay, disproportion of male and female genitalia, atrophic vagina especially in poat menopausal women, friability of the tissues, stenosis and scarring of the vagina, rough and violent thrusting of the penis during intercourse (Sally *et al.,* 2001). Women with significant coital injuries may present late due to embarrassment, fear of stigmatisation or spouse rejection.

A high index of suspicion is required to make a quick diagnosis. Careful evaluation under anaesthesia to make a correct diagnosis and management is required. Counselling of the couple should be done to prevent recurrence. Surgical repair of the fistula by transvaginal or transperitoneal route may be done with good results.

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