PREOPERATIVE DIAGNOSIS (ES):, Rectovaginal fistula.,POSTOPERATIVE DIAGNOSIS (ES):, Rectovaginal fistula.,PROCEDURE:, CPT code 57307 - Closure of rectovaginal fistula, transperineal approach.,MATERIAL FORWARDED TO THE LABORATORY FOR EXAMINATION:, Includes fistula tract.,ESTIMATED BLOOD LOSS:, 25 mL.,INDICATIONS:, The patient is a 27-year-old morbidly obese gravida three, para one, who was seen in consultation from Dr. M's office, in the office of Chattanooga GYN Oncology on 01/12/06 regarding an obstetrically related rectovaginal fistula, dating from 1998. She had an episioproctotomy associated with the birth of her seven pound son in 1998 and immediately noted the spontaneous loss of gas and stool. She had her fistula repaired by Dr. R in 2000 and did well for approximately one year, without complaint, when she again noted the spontaneous loss of stool and gas from her vagina. She has partial control if her stools are formed, but she has no control of her gas. She is a type 2 diabetic, with poorly controlled blood sugars at times, however, her diabetes has been fairly well controlled of late.,FINDINGS AT THE TIME OF SURGERY:, She had a 1 cm fistulous tract, approximately 4 cm proximal to the vaginal introitus. This communicated directly with the low rectal vault. She had good rectal sphincter tone and a very thin perineal body. The fistulous tract was excised completely and intact. The underlying rectal mucosa was closed with chromic and the perineal body was reinforced and reconstructed. At the completion of the procedure, the repair is watertight, there

were no other defects.,DESCRIPTION OF THE OPERATION:, The patient was taken to the operating room where she underwent general endotracheal anesthesia. She was then placed in the lithotomy position using candy-cane stirrups. The vulva and vagina were prepped and the patient was draped. A lacrimal duct probe was used to define the fistulous tract and a transperineal incision was made. The rectovaginal septum was developed and with an index finger in the rectum, the rectovaginal septum was easily defined. The fistulous tract was isolated and using the lacrimal duct probe, it was completely isolated. Using electrocautery dissection on the pure cut mode, the rectal mucosa was entered in a circumferential fashion as was the vaginal mucosa. This allowed for removal of the fistulous tract intact, with both epithelial layers preserved. The perineum and rectum were irrigated vigorously and then the rectal mucosa was reapproximated with a running stitch of number 4-0 chromic. The rectal vault was distended with saline and the repair was watertight. The defect was irrigated, suctioned, inspected and found to be free of clot, blood or debris. The perineal body was reconstructed with reapproximation of the levator muscles, using a series of interrupted horizontal mattress stitches of number 2-0 Vicryl. This allowed for excellent restoration of the perineal body. After this was accomplished, the defect was once again irrigated, suctioned, inspected, and found to be free of clot, blood or debris. The vaginal defect was closed with a running locking stitch of number 2-0 Vicryl and the perineal incision was closed with a

subcuticular stitch of number 2-0 Vicryl. The patient was awakened and taken to the recovery room in stable condition, after having tolerated the procedure well.