



AN UNUSUAL CASE OF PERINEOVAGINAL FISTULA IN A YOUNG FEMALE: A CASE REPORT.

General Surgery

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ABSTRACT

Urogenital fistulas may be a result of a congenital anomaly, gynaecologic surgery, obstetric trauma, cancer, radiation therapy, gynaecologic trauma or instrumentation or infection (1). Perineovaginal fistulas, an opening through the vagina into the perineum, are extremely rare types of urogenital fistulas most often occur secondary to some other cause or perianal disease. In this report, we discuss an unusual case of perianal fistula in a young female of 22 years of age, who presented with intermittent history of passage of perianal mucoid discharge for two months duration which gets temporarily healed with conservative management and again recurs. Imaging studies revealed a blind sinus track ending at the left intersphincteric space. Diagnosis of a perineovaginal fistula was confirmed on fistulotomy and examination under anaesthesia. This incidental finding is an extremely rare presentation in this age group.

KEYWORDS

Perineovaginal fistula, Fistulotomy, Young female, Idiopathic

INTRODUCTION

Perineovaginal fistula, a very uncommon urogenital fistula occurring in women, was first reported and published by Kemal Beksac et al. in 2014 as a complication of perianal surgery in a patient with Sjögren's Syndrome (2). They often occur as a result of any congenital anomaly, gynaecologic surgery, obstetric trauma (e.g. in episiotomy or obstructed labour), cancer, radiation therapy, gynaecologic trauma or instrumentation or infection. Idiopathic finding is an extremely rare occurrence in such an age group without previous instrumentation or infection. Management of perineovaginal fistula becomes very difficult if the wall of the vagina gets traumatised or devascularized during dissection (3). Therefore careful examination under anaesthesia and repair by fistulotomy with perineoplasty is the optimal treatment for such women.

CASE REPORT

22year old woman presented to the emergency department with complains of recurrent passage of mucoid perianal discharge since two months. She was treated conservatively with warm sitz baths, broad spectrum antibiotics comprising of metronidazole and cephalosporin and local analgesics for symptomatic pain relief. Her perineal symptoms subsided completely for two weeks and then recurred with a perianal abscess which was locally drained under antibiotic coverage. The abscess cavity healed gradually with regular saline dressing. After an asymptomatic period of 2-3 weeks she again had similar mucoid discharge from the perianal region. She also gave history of significant leucorrhoea irrespective of her regular menstrual cycles and prior to the appearance of her perineal symptoms (Fig 1, 2).

She appeared pale and averagely built. On digital rectal examination, an external opening was found 2cm posteriorly and left to the anal orifice. The anal mucosa appeared normal with no thickness or induration on introduction of the finger. The internal opening was not felt on thorough examination. The anal sphincter tone appeared normal. The fistulogram report suggested a blind sinus track that ended in the intersphincteric space. She was then hospitalized and fistulotomy was carried on under regional anaesthesia and methylene blue dye guidance. A malleable probe was introduced into the blind track in the perineum which met resistance and with further gentle probing, the internal opening was revealed at the vaginal orifice. Thus the diagnosis of perineovaginal fistula was established.

OPERATIVE FINDINGS

Following fistulotomy, entire fistula tract was excised and vaginal mucosa, perineal subcutaneous tissue, and perineal skin were repaired in layers. The remaining fibrous scar tissue was unroofed. Fistulectomy with perineoplasty repair was done using absorbable catgut sutures. The resected portion was sent for histopathological study.

POST OPERATIVE FINDINGS

Postoperative period remained uneventful where the patient improved gradually and she was discharged on day four. No recurrence of symptoms or impairment of continence seen and follow-up examinations at 6-week, 3-month, and 6-month postoperative period were completely normal.

HISTOPATHOLOGICAL REPORT

Histopathology report was consistent with nonspecific inflammation in Fistula in Ano comprising of foreign body giant cells and granulomatous tissue containing many eosinophils and proliferating capillaries.

DISCUSSION

Perineovaginal fistula is a rare problem of lower genital tract (4). It may occur as a complication of episiotomy and perianal diseases (5, 6). Infections and immune system problems must also be considered as predisposing factors (7, 8). To the best of our knowledge, this is the first published idiopathic perineovaginal/ cutaneous fistula case reported, as an incidental finding. Very few case reports have been published so far regarding the perineovaginal fistula which either occurred as a complication of perianal disease, inflammatory bowel disease or any gynaecological/obstetric surgery. Young female with such a finding is again a very rare presentation without any prior gynaecologic instrumentation. In the clinical practice, the anatomical and functional integrity of anal sphincter could be disturbed due to episiotomy complication or a tear to the sphincter after vaginal birth (5, 2).

However, in our case vaginoperineal integrity was disturbed due to perianal fistula operation. The ideal treatment in such a case is fistulectomy along with the repair of vaginal wall through perineoplasty or culpoplasty.

CONCLUSION

Perineovaginal fistula is an uncommon finding and patients presenting with such conditions often get ignored during the early course of both conservative and surgical management. Therefore thorough clinical examination, imaging studies and early prompt treatment is required for better recovery of such conditions.



Figure 1: shows the vaginoperineal fistula with a thin probe passing through it. Vaginal wall and the perineum are opened with appropriate incision and fistula tract is visualized. Entire track is excised.



Figure 2: shows perineoplasty after fistulectomy.

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