

TREATMENT TACTICS FOR RECTOVAGINAL FISTULAS

Alimova Zulayho Quvondiqovna

Samarkand State Medical University

Sherbekov Ulugbek Akhrorovich

Scientific advisor: DSc

Samarkand State Medical University

Abstract. Rectovaginal fistulas are a challenging and unresolved issue in the fields of colorectal surgery, pelvic surgery, gynecology, and urology. Numerous surgical methods have been proposed to treat rectovaginal fistulas. However, the rate of disease recurrence and postoperative complications remains high. This is largely due to the lack of an individualized approach in determining the surgical method for treating rectovaginal fistulas, necessitating the exploration of new surgical technologies and the development of treatment algorithms.

Keywords: Rectal fistulas, flesh, coloproctology, paraproctitis

Introduction. Rectovaginal fistulas represent 59.1% of all genital fistulas, with low and medium-level fistulas being the most common. These fistulas cause significant social issues, leading to adaptation problems, severe emotional and physical suffering for patients, and complex relationships with family and society. These pathological conditions can lead to incontinence of gas and feces, often developing against the backdrop of chronic anorectal pathology complicated by purulent infections. Prolonged illness makes surgical treatment difficult and increases the risk of postoperative recurrences. Rectovaginal fistulas are most common in young, working-age women. Pathological childbirth, characterized by prolonged labor, long intervals without amniotic fluid, and perineal tears, are the primary causes. In these cases, fistulas are typically located low, have a lip-like structure, and involve scarred perineal tissues, often leading to anal sphincter insufficiency. Other causes include abscess rupture into the vagina during acute paraproctitis, complications of inflammatory bowel diseases like Crohn's disease, diverticular disease, rectovaginal septum injuries, and pelvic organ surgeries. Involuntary discharge of feces and gases into the vagina causes maceration and irritation of the perianal skin and vaginal mucosa, complicating the persistent, sometimes unsuccessful, treatment of vaginitis caused by intestinal microflora contamination. High-pathogenic bacterial infections in the vaginal area can lead to exacerbations of urinary tract inflammatory diseases.

Purpose of the study: The main goal of this research is to improve treatment outcomes for patients with rectovaginal fistulas by optimizing surgical approaches and techniques. This involves a thorough evaluation of both immediate and long-term results of surgical treatments conducted on 23 patients with varying degrees of rectovaginal fistula complexity at the SamMU Clinic's Coloproctology Department from 2019 to 2024.

Materials and Methods: Patients were primarily admitted due to childbirth injuries, perineal tears of grades II-III, followed by infections from the rectal lumen, and in two cases, spontaneous drainage of acute paraproctitis into the vaginal lumen. The patients underwent standard examinations, including gynecological assessments and vaginal microbiota evaluations. The diagnostic algorithm included rectal and vaginal examinations, anoscopy, rectoscopy, complex anorectal manometry, profiling, fistulography, endorectal and vaginal ultrasound, proctography, spiral or magnetic resonance imaging, and electromyography for

severe perineal scar deformities. Preoperative preparation involved vaginal sanitation with antiseptics and, where possible, fistula tract sanitation.

Two categories of surgical interventions were applied, which are considered the most pathogenetically justified. Patients were divided into groups based on stratified randomization principles, considering postoperative prognosis quality indicators. The main group included patients with the worst postoperative prognosis, such as those with perineal tears during childbirth, acute paraproctitis, pelvic floor prolapse, and relaxation. The control group consisted of nine patients who underwent fistula excision with closure of the internal rectal opening, followed by layer-by-layer suturing of the surgical wound and vaginal wall plastic surgery using their mucosa without sphincter-levatoroplasty components. In the main group of eight patients, the surgery was modified by performing segmental proctoplasty of the internal fistula opening in the rectum with a full-thickness flap, fixed with sutures around the wound perimeter, and the vaginal wall defect was covered with a mobilized mucosal-submucosal flap after preliminary anterior sphincter-levatoroplasty.

Results and Discussion

In the postoperative period, favorable conditions were created for wound healing and rapid patient recovery, including specific regimens, diets, correction of general and local disturbances, and dressings. Daily dressings and vaginal douches with antiseptics were performed from the first postoperative day. A comparative analysis of surgical treatment results showed that in the control group, with wound healing times up to 20 days, one recurrence occurred due to inadequate separation between the vaginal and rectal walls, wound infection, and suture erosion. Antibacterial therapy was administered for 7 to 10 days. Pain relief was managed with non-narcotic analgesics for 3-6 days.

In the main group, with healing times up to 15 days, no recurrences were registered. However, one case of infiltrative inflammation in the postoperative wound was observed, which was resolved conservatively within two weeks. Antibacterial therapy lasted 5-7 days, and pain management continued for up to 6 days without further need for parenteral analgesics. Laboratory tests showed no significant inflammatory reactions, except in cases with recurrences or infiltrative wound changes.

Conclusion. The study identified significant advantages of the proposed method involving anterior sphincter-levatoroplasty. This technique allows for layered restoration of the rectovaginal septum structure, preventing infection spread from the rectal lumen to the septum and vagina, thereby reducing postoperative complications and recurrences. This method also shortens wound healing time, reduces the duration of antibacterial therapy, and minimizes the need for pain and anti-inflammatory medications. The proposed radical excision method, supplemented by segmental proctoplasty, anterior sphincter-levatoroplasty, and vaginal wall plastic surgery with a mobilized mucosal-submucosal flap, significantly reduces postoperative complications and recurrences. Creating a fascial-muscular layer between the rectovaginal walls restores the anatomical structures of the perineum and pelvic floor, preventing the spread of infections.

These stable positive results in the second clinical group confirm the correctness of the chosen tactics, especially for patients with the highest risk of complications and recurrences. The method also improves the functional characteristics of the rectum and its sphincter apparatus, as evidenced by the immediate and long-term results. The technique demonstrates good cosmetic effects and practical benefits, including shorter hospital stays and fewer postoperative



complications, highlighting its social and economic efficiency. Further refinement of the technique is needed, but its current advantages are clear.

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