Management of Fistulas Prostatorectales: Experience with Eight Cases

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Management of Fistulas Prostatorectales: Experience with Eight Cases

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Abstract

Introduction and objectives: Prostatorectal fistulas are rare. The main aim of this study is to evaluate the different clinical types of fistulas; the diagnostic methods and the different therapeutic approaches.

Materials and methods: This is a retrospective study between 1996 and 2010 including 08 patients. The diagnosis was based upon DRE, retrograde uretrocystography; uretrosopy; rectoscopy and intravenous urography. Many types of surgical approaches were made but the mostly used was York Mason technique. Postoperative follow up was based upon clinical examination and the realization of a retrograde uretrocystography at 02months interval.

Results: The mean age of our patients was 51 years old (19-78). The diagnostic triad was based upon (urinary passage from the anus; pneumaturia; fecaluria) DRE have showed the presence of rectal fistula in 07 patients that was confirmed using retrograde uretrocystography. 05 of them had a past history of prostate surgery. The choice of surgical treatment was different from patient to another. 02 of them have undergone intestinal by-pass; another 02 were treated using internal uretrotomy and the last 03 patients have been cured using york mason technique in which 02 of them via transperineal approach and 01 of them through trans-anal technique. The post operative follow up was simple.

Conclusion: Prostato-rectal fistula is a rare abnormality in which the main etiology is prostate surgery. York Mason technique is the mostly preferred approach by most authors.

Introduction

Prostato rectal fistula is an abnormal communication between the urethra and the rectum. They are usually iatrogenic hence due to the improvement of modern urology such kind of disease became rare. Clinical signs are mainly urinary passage from the anus during voiding; pneumaturia and fecaluria. DRE; retrograde uretrocystography; rectoscopy and iv urography enable us to establish the diagnosis and to precise the place of the lesion. The deepness of fistula localization explain the surgical approach difficulty; therefore many ways of treatment were established. The objective of this study is to evaluate and to analyze the different clinical aspects; diagnostic methods and to precise the different surgical modalities mainly york mason method.

Methods

This retrospective study was enrolled between 1996 and 2010; including 08 patients having prostato-rectal fistula. We analyzed the files of this patients taking into consideration their clinical and paraclinical data’s; therapeutic attitude and post-operative follow up. The diagnosis was made by DRE; retrograde UCG; uretrocystography; rectoscopy and iv urography.

York Mason approach was one of the main surgical modalities used. The postoperative clinical evaluation was made at the moment of catheter ablation; at the 2nd month and then at the sixth month following surgery. We also performed a control retrograde UCG at the second and the sixth month of the operative act.

Results

The mean age of our patients was 51 years old (19-78) with a mean diagnostic time of 03 months. Illustration 1 shows the different clinical signs that have been reported. DRE have made the evidence of fistula in 07 patients. Retrograde UCG confirmed the diagnosis (Illustration 2 and 3). Illustration 4 shows the main etiologies of such fistulas. -2 patients have been treated via intestinal by-pass-02 via internal uretrotomy-03 by using york-mason technique in which 02 of them via transperineal approach and 01 of them through transanal technique. The control retrograde uretrocystography have demonstrated the closure of the fistulous tract in all patients (Illustration 5). The mean follow up was 03 years.

Discussion

Prostate rectal fistulas are usually iatrogenic and are
seen mainly after the fiftieth year [1, 2]. In our study we found the same results with patient mean age of incidence of 51 years-old and an iatrogenic cause in 5/8 patients. Post traumatic fistulas represent 30% and are usually secondary to pelvic fracture [3]. The finding of fecaluria is rare and it shows how much the communication is important and may lead to loco regional infection with urethprostatitis [4]. The diagnostic key is to perform retrograde UCG which was done in 7/8 patients. The making of an iv urography is important specially in case of fecaluria ; to evaluate the upper urinary collecting system [7,8]. The treatment is based initially upon urinary by-pass. This procedure isn’t satisfactory for important fistulas ; however it helps in the closure of small ones [9]. In this study 02 patients were treated by internal uretrotomy associated with bladder drainage. Fecal material by pass using intestinal stomy isn’t an obligation and was done to only 02 of our patients [9, 10]. 03 patients with upper rectal fistulas were treated using york mason technique [11, 12, 13]. The advantage of such approach is the short operative time; a better exposure and less complication and the preservation of sexual function and urinary continence [14, 15].

Conclusion

Prostato rectal fistulas are rare conditions. Their etiology is dominated by prostate surgery. When surgery is indicated many ways of reparation are possible. The surgeon should choose the most suitable technique. We recently found that many authors prefer York mason approach.

References

Illustrations
Illustration 1

Clinical Signs

<table>
<thead>
<tr>
<th>Clinical signs</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue of urine Through the anus</td>
<td>6 patients</td>
</tr>
<tr>
<td>Pneumaturia</td>
<td>2 patients</td>
</tr>
<tr>
<td>fecaluria</td>
<td>3 patients</td>
</tr>
</tbody>
</table>
Illustration 2

UCG showed opacification of rectum
Illustration 3

Large Fistula. Rapid Opacification of Rectum
Illustration 4

Etiologies of Fistulas

<table>
<thead>
<tr>
<th>etiologies</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>transurethral resection of the prostate</em></td>
<td>2 patients</td>
</tr>
<tr>
<td><em>Adénomectomie par taille vésicale</em></td>
<td>3 patients</td>
</tr>
<tr>
<td><em>complex pelvic trauma</em></td>
<td>2 patients</td>
</tr>
<tr>
<td><em>Urethral stricture</em></td>
<td>Un patient</td>
</tr>
</tbody>
</table>
Illustration 5

The control UCG confirming the closure of the Fistula
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