LETTER TO THE EDITOR

Is minimally invasive transanal surgery an alternative for rectal-urinary fistula correction?*

¿Es la cirugía transanal mínimamente invasiva una alternativa para la corrección de fistulas recto-urinarias?

Dear Editor,

Rectal injury is a serious and rare complication in the radical treatment of prostate cancer. The incidence reported in radical prostatectomy (RP) is 0–9% in the open surgery and 1–2.7% in the laparoscopic pathway.1

Between 0.6 and 9% of the lesions after RP will end as fistulas diagnosed late, originating from an inadvertent rectal injury or a defective closure of the rectal wall. Their incidence is 0.2–2% in patients undergoing RP, 0.4–8.8% in brachytherapy, 0–6% postradiotherapy, and 0.4% in cryotherapy.

The patient with recto-urinary fistula may present pneumaturia, fecaluria, urine leakage from the rectum, fever, urinary tract infection, sepsis, pelvic abscess, and/or peritonitis. For the diagnosis, techniques such as cystourethrography, cystourethrocscopy, colonoscopy, or barium enema are employed.

Spontaneous closure of the fistula is rare and one must resort to surgical closure if with conservative treatment it has not closed after 3–6 months.

One of the most important aspects for the management of recto-urinary fistulas is choosing an appropriate approach in the first attempt to close, since the initial failure complicates subsequent repair attempts. The fistula location, size, and previous treatment of the patient are important aspects to define a new surgery. Rivera1 suggested a classification of 5 stages for the correct choice of the procedure.

There are different techniques for the correction of the fistula and different surgical approaches: abdominal, perineal, and posterior sagittal,2,5,6 but there is no consensus about the ideal surgical technique.

The transperineal approach, ideal in urethrorectal fistulas, allows for the interposition of connective tissue. Kilpatrick and Mason used the posterior transsphincteric approach (dividing the sphincters) to have more direct access to the fistulous tract. The York Mason technique is one of the most appropriate for the treatment of recto-urinary fistulas with a high probability of success and low morbidity.

In the transanal approach, described by Parks, a rectal flap proximal to the fistula is used after resection of the fistulous tract. The anterior sagittal transsphincteric access described by Gecelter in 1973 was used by Castillo5 in the management of 5 vesicorectal fistulas with positive results.

We report the case of a 65-year-old patient with recurrent recto-vesical fistula operated by transanal minimally invasive surgery (TAMIS) using the Gel Point Path® device.

The patient with prostate adenocarcinoma underwent open radical prostatectomy in November 2011. In the immediate postoperative period, he had fecaluria and he was reoperated due to vesicorectal fistula (fistulorrhaphy, Hartman, and end colostomy were performed). After recurrence, in December 2011, he required further surgery abdominally with fistula closure in 3 planes, reimplantation of both ureters, and new vesicourethral anastomosis.

Given the persistence of the fistula, he was referred to our hospital, where in May 2012 fistulorrhaphy was performed by means of the York-Mason technique. At 2 months, the patient had a new relapse, observing the fistula, smaller size, 6 cm from the anal verge.

In April 2013, he underwent, in the HCUVA, fistulorrhaphy using a laparoscopic endoanal approach with the Gel Point Path® device (Fig. 1) with resection of the fistulous tract and closure on 2 levels: bladder and rectal (Figs. 2 and 3). He was discharged without debit of urine through the rectum and with permanent catheter for 3 months.

We consider that the TAMIS with the Gel Point Path® device, in addition to providing excellent exposure of the fistulous orifice, makes it possible to suture and make adequate hemostasis. Correction of vesicorectal fistulas can be carried out with this approach effectively and reproducibly, posing as an alternative for their management.

LETTER TO THE EDITOR

References


G.A. Gómez, P.F. Gutiérrez*, P. López-Cubillana, P. López

Servicio de Urología, Hospital Clínico Universitario Virgen de la Arrixaca, El Palmar, Murcia, Spain

*Corresponding author.
E-mail address: felgutiguti@hotmail.com (P.F. Gutiérrez).

Figure 1 Placement of the Gel Path Point® device.

Figure 2 Fistulous orifice with bladder probe in the background.

Figure 3 Closure of the fistula.