BRIEF REPORT

Rectovesical fistula; a rare complications of appendicitis

SAEED KARGAR1, NAEIMEH HEIRANIZADEH2, SHADI KARGAR 3
1 Associated professor, Department of General Surgery, Shahid Sadoughi University of Medical Sciences, Yazd, Iran 2 Resident of Surgery, Department of General Surgery, Shahid Sadoughi University of Medical Sciences, Yazd, Iran 3 Medical student, Shahid Sadoughi University of Medical Sciences, Yazd, Iran

ABSTRACT

Rectovesical fistula is a rare complication of undiagnosed acute appendicitis. This fistula often presents recurrent symptomatic Urinary Tract Infection (UTI). A case of Rectovesical fistula in a 41-year-old male diabetic patient is described. A perforated appendicitis caused the connection between the base of the bladder and the rectum. There was no appendicovesical fistula connecting with the caecum. In this case a primary resection of the involved rectum was done, the fistula tract excised and simple closure of the bladder and appendectomy was performed.

Key words: rectovesical fistula, appendicitis, single stage resection

INTRODUCTION

The Rectovesical fistula is a serious surgical problem as it seldom closes spontaneously and may lead to death. Fistula may be either congenital or acquired (e.g. inflammatory like appendicitis, surgical and neoplastic). The most of patients primarily have urinary tract complaints. Signs include abnormal urinalysis findings, malodorous urine and debris in the urine, hematuria and UTI. These patients usually treated late because the colovesical fistula is accompanied by the unusual symptoms like diarrhea, frequency, dysuria and urgency.

The diagnosis of Rectovesical Fistula (RVF) is difficult and usually delayed. Barium enema and colonoscopic examinations, magnetic resonance imaging, ultrasonography, cystography, IVP have minimal role in RVF diagnosis. Computed tomography (CT) detects air within the bladder earlier and without equivocation when compared with other imaging techniques. It can also determine the extent of pericolonic inflammation. Therefore, CT plays an important role in preoperative surgical planning and post operative follow up.

We report the case of a 41 years old man presenting hematuria, pneumaturia initially investigated with cystoscopy and finally attributed after an extensive investigation to rectovesical fistula related to unusual symptomatic appendicitis.

CASE REPORT

A 41-year-old male diabetic patient presented with persistent dysuria, frequency with leukocyturia and hematuria. He was investigated with cystoscopy by a urologist. The result of biopsy through cystoscopy was cystitis cystic glandularis with severe acute and chronic cystitis. He had lower abdominal pain, fever and diarrhea history in 7 months ago that he didn’t perform any work up. While this patient was referred in our service he had no signs in physical exam of abdomen in spite of the presence of pneumaturia. His chief complaint was: my urine is dark and malodor that looks like fecal material, sometimes it has air bubble. His urine culture was positive and the predominant organism was E-coli. The result of CBC was normal except mild leukocytosis. The blood Urea Nitrogen, creatinine and electrolytes were normal. An RVF was confirmed by CT, which showed gas in the bladder and thickening of the bladder wall. Fat plain
between the rectum and urinary bladder is obliterated. There were a few tiny air bubbles within the fistulous tract which is also almost 2 cm in length. No diverticulitis or additional mass was seen. Findings also were confirmed with IVP (Fig. 1). Tract of fistula had been shown in this IVP. Finally laparotomy with single stage resection was done. Retrograde appendectomy, resection of involved rectum and fistula tract was performed. Primary anastomosis was done then defect of bladder wall was repaired too. Surgical pathology report was no evidence of malignancy and the properties of appendicitis and chronic cystitis was described. This patient was followed up two weeks, one month, six month and one year later. He did not have any complaint and his physical exam was normal.

DISCUSSION

Fistula formation often occurs between the two adherent structures or they may communicate via an abscess cavity. Inflammatory, neoplastic or degenerative changes in the involved viscus can cause the fistula tract. In the literature pneumaturia was reported in some patients. Many patients’ symptoms were mild, and it was common for the patient to wait for several months before seeking medical care. Although the principle cause of RVF is intestinal origin, most of patients complain from urologic symptoms. As the principle cause of RVF is intestinal origin, most of patients complain from urologic symptoms. As the principle cause of RVF is intestinal origin, most of patients complain from urologic symptoms. As the principle cause of RVF is intestinal origin, most of patients complain from urologic symptoms. As the principle cause of RVF is intestinal origin, most of patients complain from urologic symptoms. 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