ALGERIAN SOCIETY OF PEDIATRIC SURGERY

# RECTOURINARY FISTULA FOLLOWING A TRANS ANAL PROXIMAL RECTOSIGMOIDECTOMY

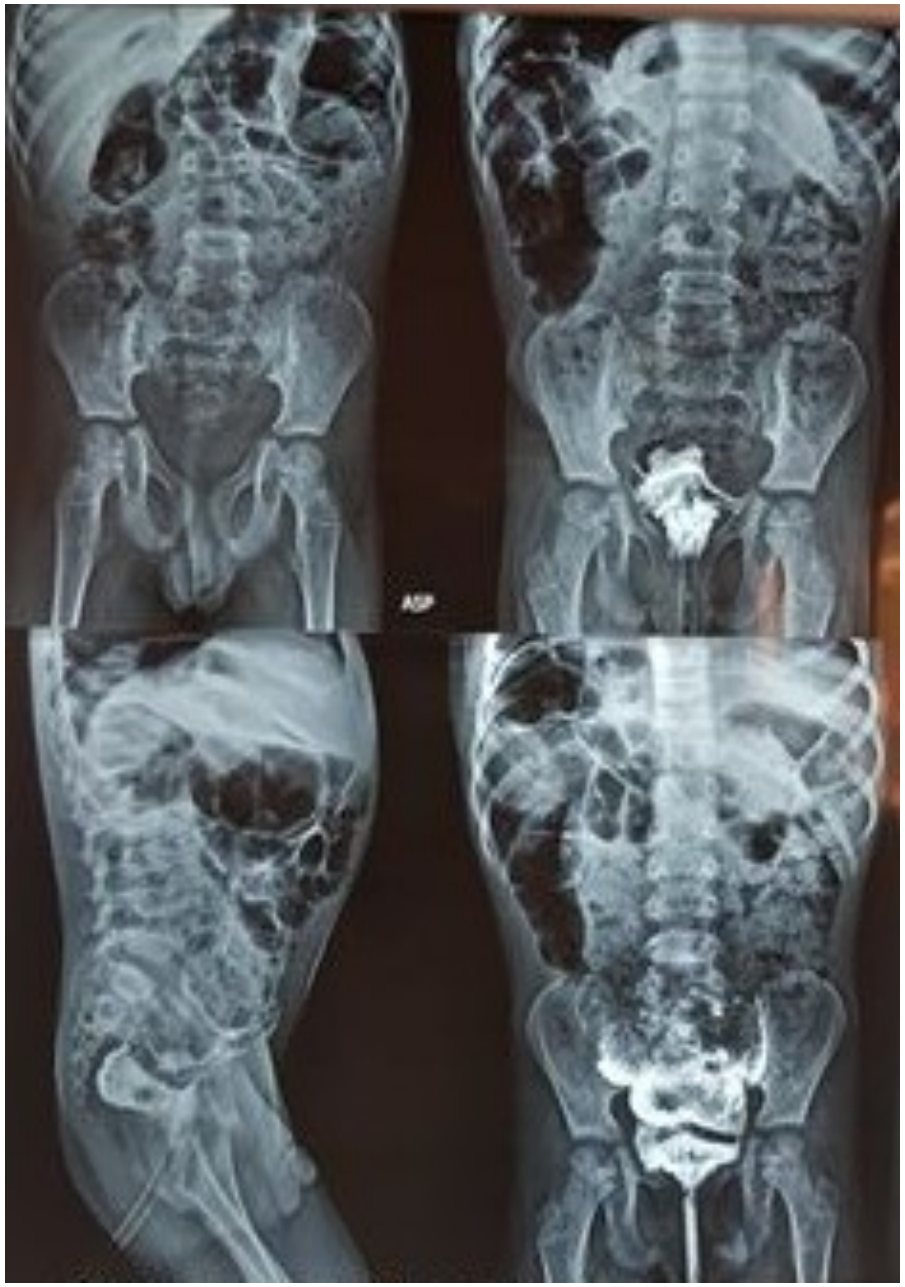
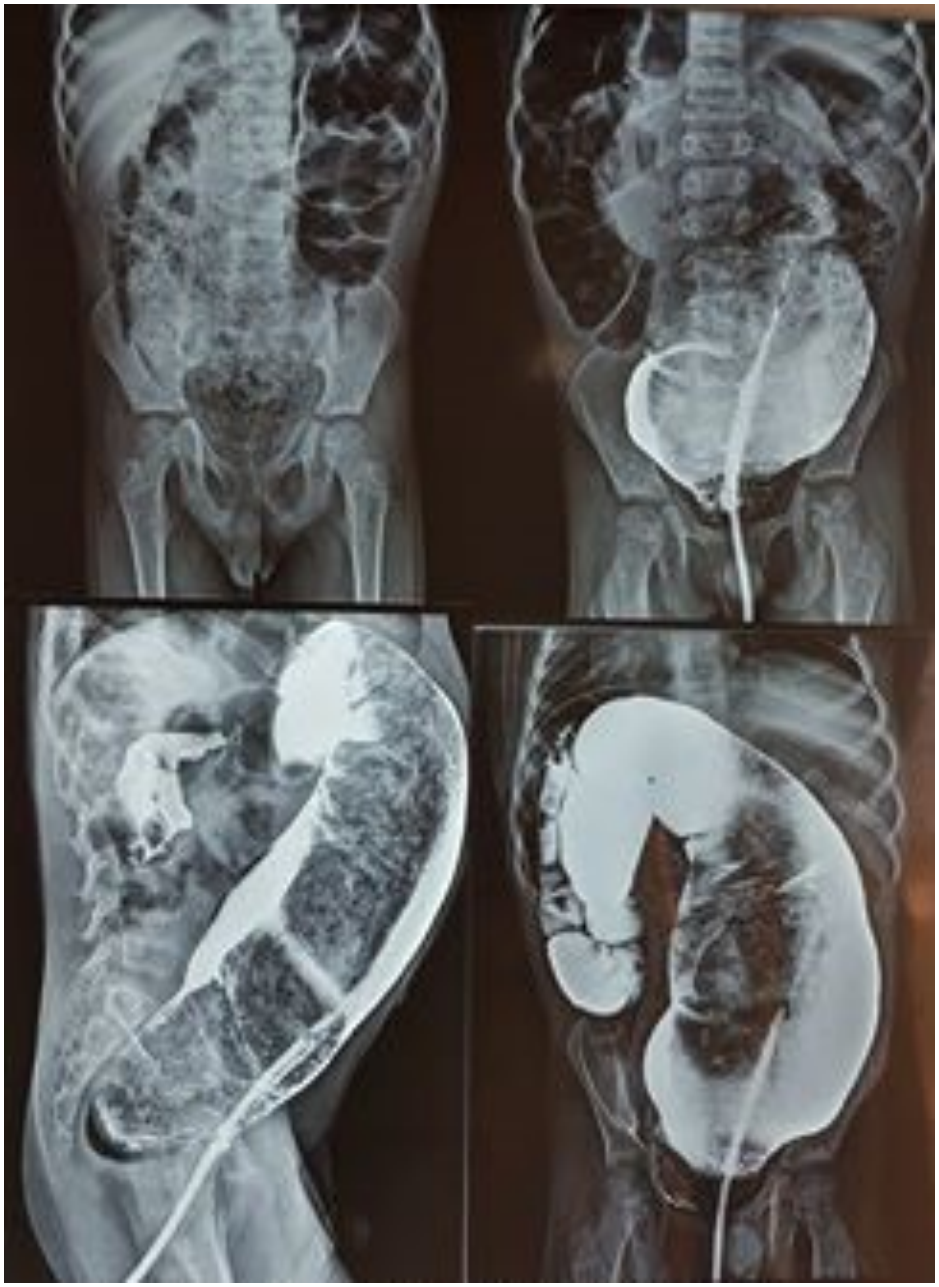
## for chronic idiopathic constipation

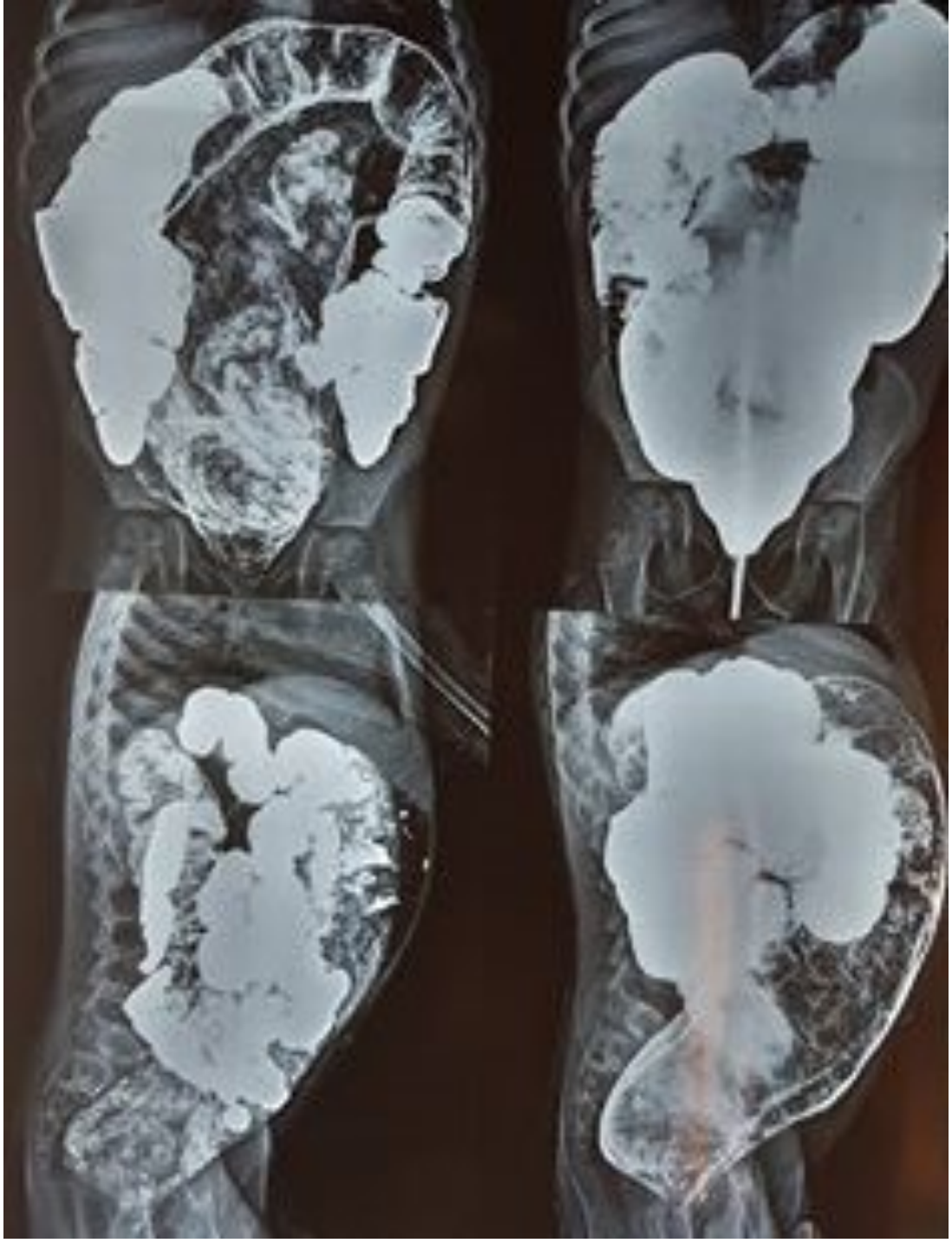
**Dr SARRA AGGOUN**

**CHU Sétif ALGERIA**

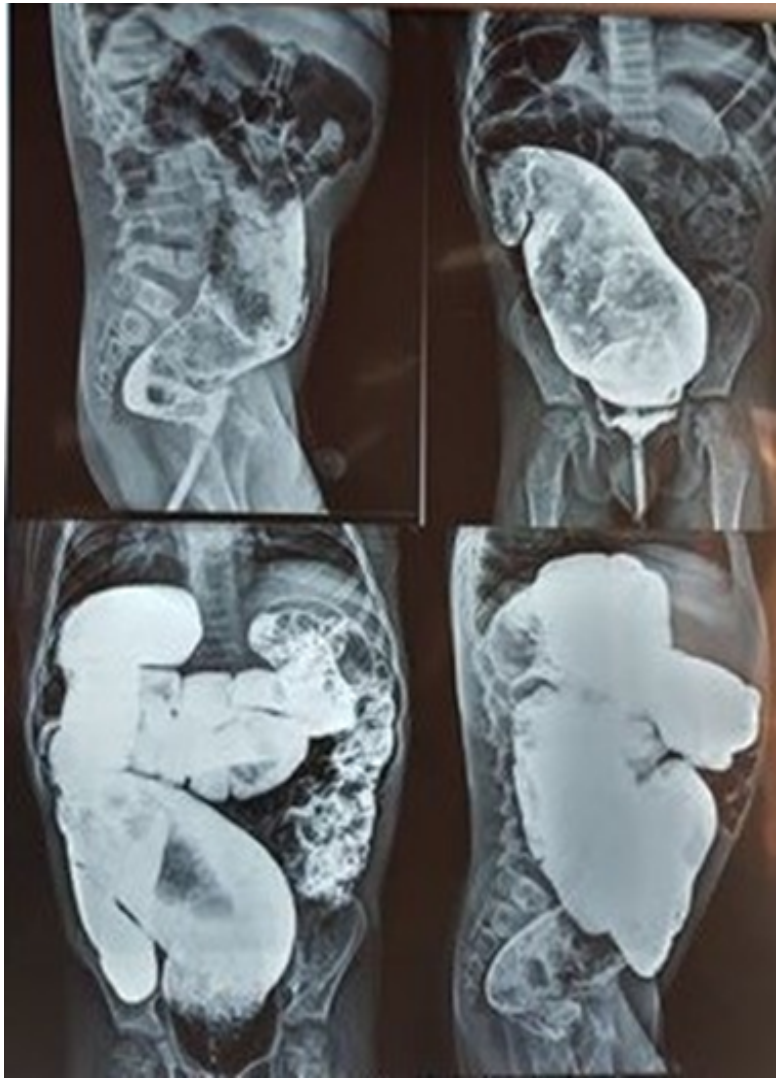
- 11-year-old boy, developmentally delayed, from a very poor region.
- He suffers from chronic constipation and all his life he was been wearing diapers.
- One bowel movement every 10 to 15 days, with recurrent abdominal pain and distention.
- Passing stool was very painful with frequent soiling.

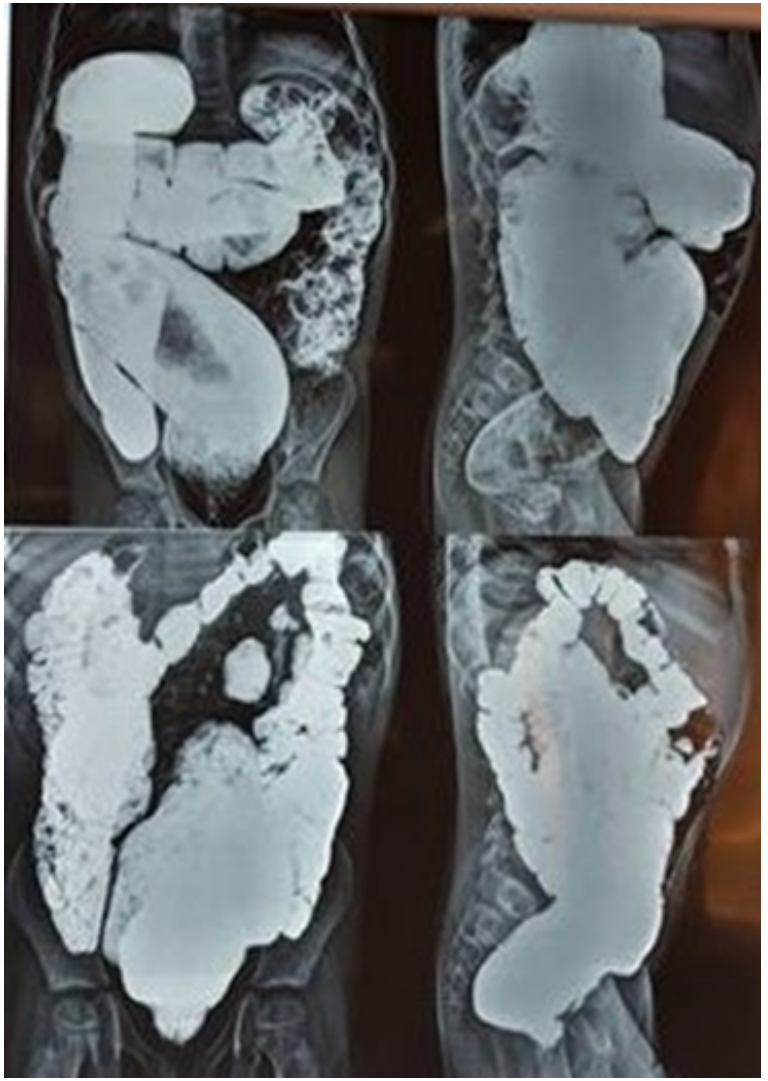
- On physical examination: multiple palpable fecalomas, normal anus.
- No spinal dysraphism.
- Anorectal manometry -- normal findings.
- He was referred to us 10 months ago with a barium enema.



- We began constipation management: diet, physical activity, laxatives forlax 10-g gradual dose up to 50 g per day and frequent enemas for 4 months
- He has never had spontaneous stool despite oral laxatives
- We asked for a second barium enema





- It was a severe chronic idiopathic constipation associated with a MEGA recto-sigmoid not responding to laxatives with nausea, vomiting, and abdominal pain...
- We decided to perform surgery and to do a trans-anal proximal rectosigmoidectomy, according to the technique described by **Dr. LUIS DE LA TORRE** in his recent article

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# Transanal proximal rectosigmoidectomy. A new operation for severe chronic idiopathic constipation associated with megarectosigmoid

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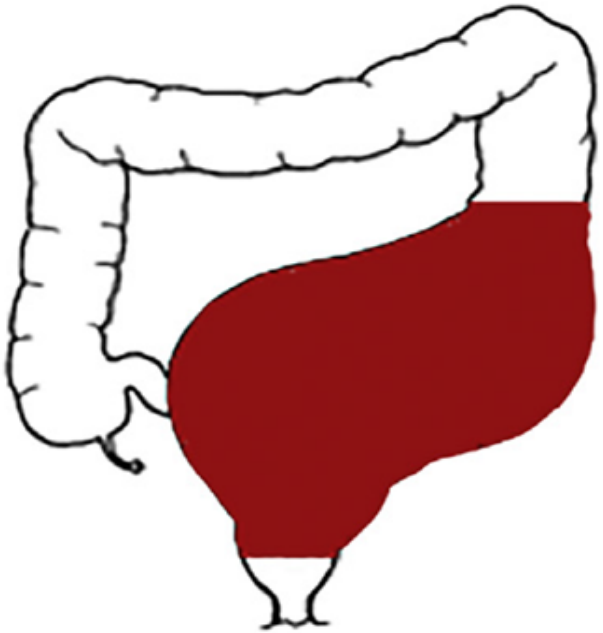
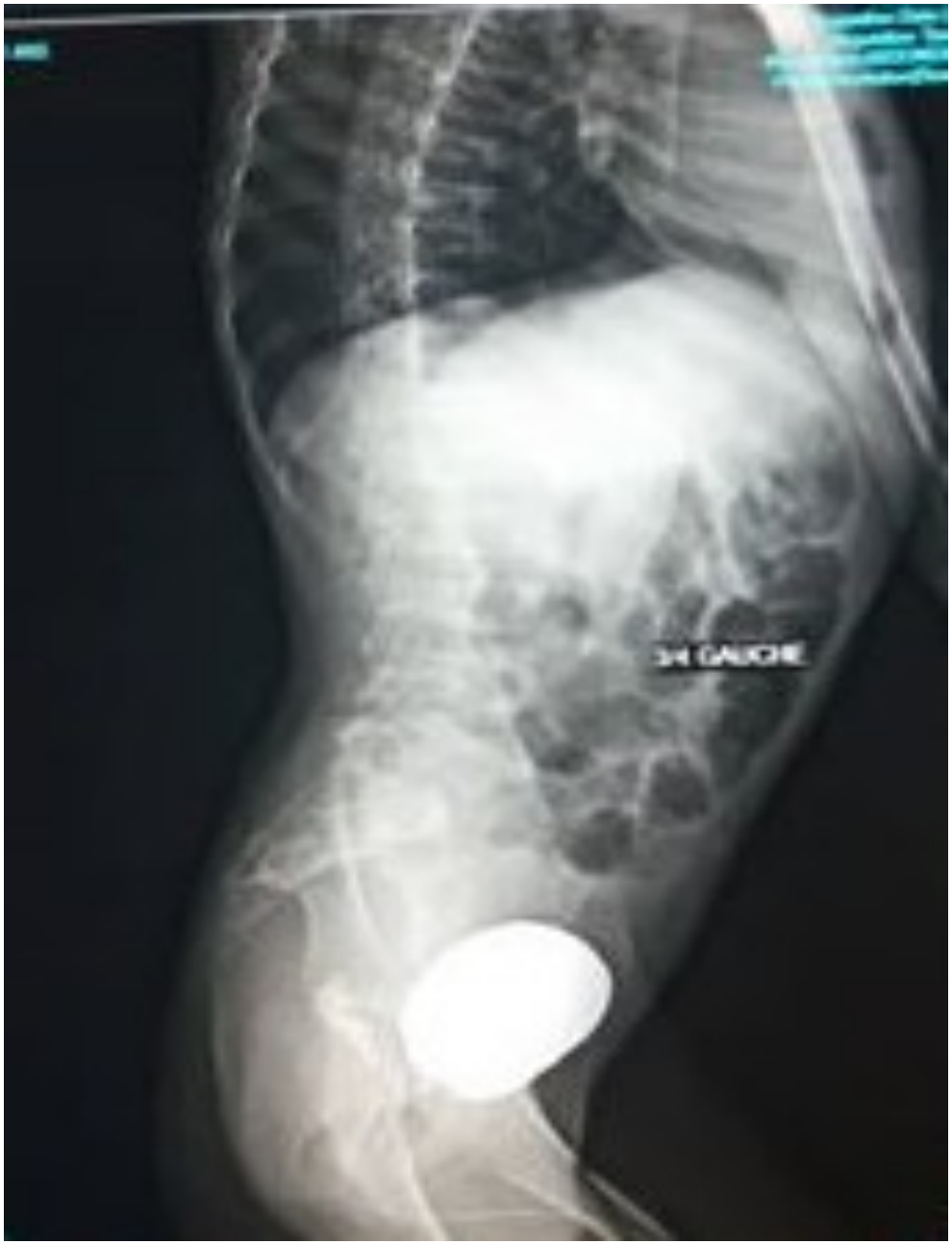
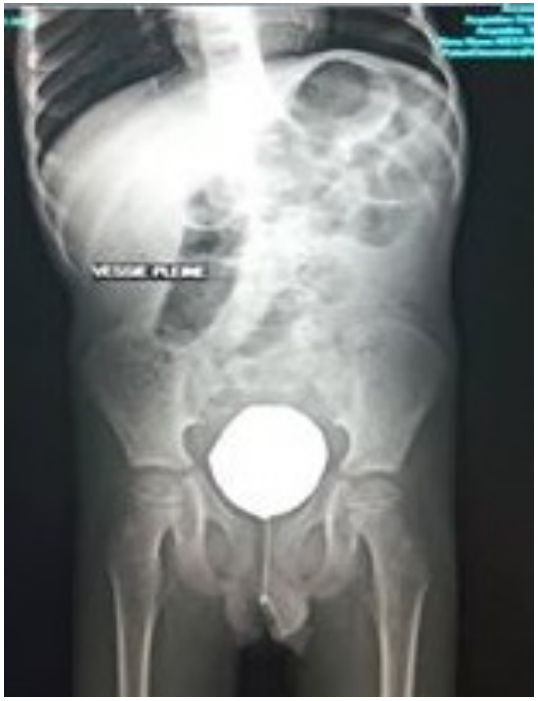
## Proximal Rectosigmoidectomy

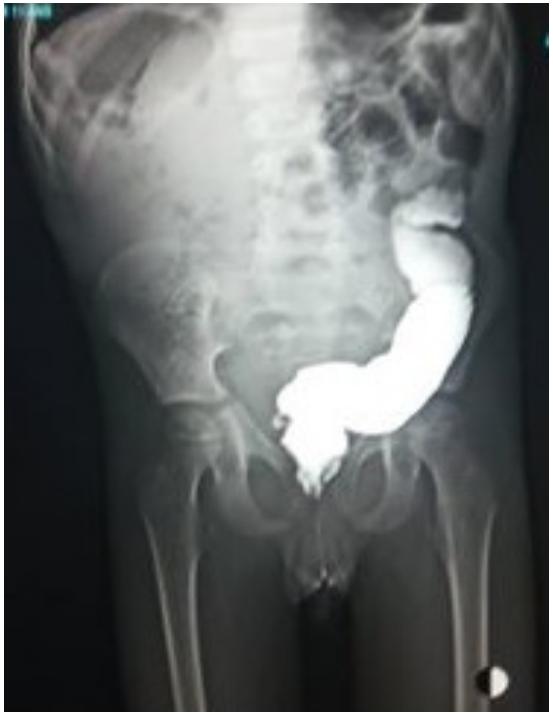


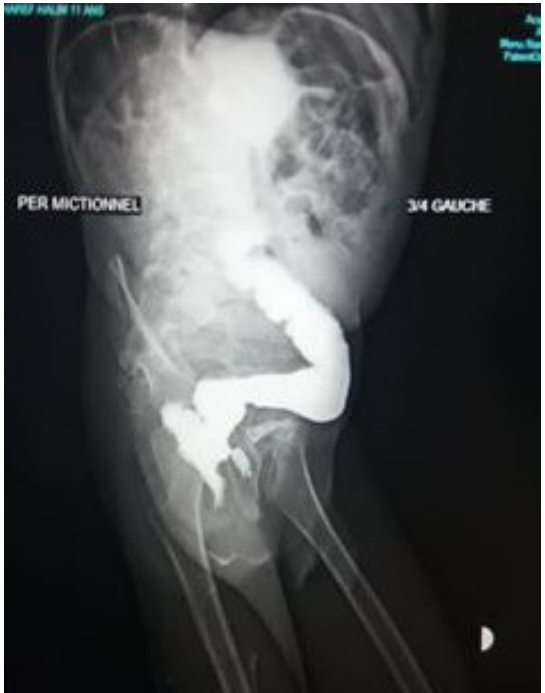
- There were no perioperative difficulties in performing the procedure
- At the end we noticed a slight hematuria, which resolves immediately. We maintained the Foley catheter for 48 h then we removed it.
- Postoperative period was uneventful and the child was discharged on the 8th postoperative day after having passed stool spontaneously and with normal micturation.

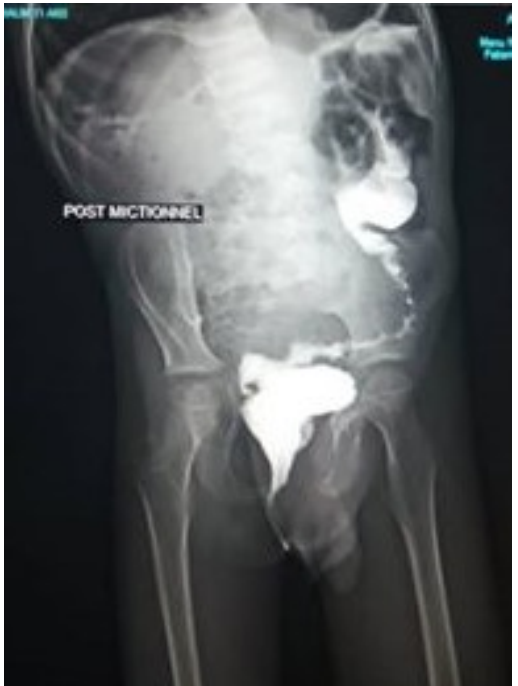
- On the 25th postoperative day, the mom noticed that he had dysuria and he was passing urine through the anus.
- We performed a voiding cystourethrography, which confirmed the recto-urinary fistula.


S4 GAUCHE






PER MICTIONNEL
3/4 GAUCHE


POST MICTIONNEL

# What would you do?

1. Open a vesicostomy
2. Open a colostomy
3. Offer a reoperation
4. I don’t know

- Patient underwent the opening of a diverting colostomy 1 month ago
- But he is still passing urine through the anus.

**Our questions:**

1. **How could you explain the occurrence of the fistula?**

2. **With which technique can we correct it?**

**THANK YOU VERY MUCH**

# Discussion

When all the medical resources have been exhausted after proper bowel management, then the surgeon needs to consider surgical treatment.

Every surgeon needs to decide what operation will be performed, based on his/her skills, knowledge, experience and own circumstances.

This operation requires an experienced and knowledgeable surgeon.

Not every pediatric surgeon should do this operation. A pediatric surgeon interested in performing this operation needs additional training in colorectal surgery to successfully realize this novel technique.

*Transanal proximal rectosigmoidectomy. A new operation for severe chronic idiopathic constipation associated with megarectosigmoid. J Pediatr Surg 2019 in press.*