

Conservative management of a rectovaginal fistula caused by a Gellhorn pessary. A case report

Samaa Siyam,¹ Ismaiel Abu Mahfouz,² Mais Al-Attar,¹ Roaa Khatatbeh,¹ Esraa Qandil,¹ Leen Saifan¹

¹Department of Obstetrics and Gynecology, The Specialty Hospital, Amman; ²Department of Obstetrics and Gynecology, Faculty of Medicine, Al Balqa' Applied University, Al-Salt, Jordan

Abstract

A 72-year-old woman presented with stage III pelvic organ prolapse (POP) and chose a vaginal support device (VSD) after

Correspondence: Ismaiel Abu Mahfouz, Department of Obstetrics and Gynaecology, Faculty of Medicine, Al Balqa' Applied University, 19117, Al-Salt, Jordan.
Tel.: 00962797143332.
E-mail: Ismaiel.mahfouz@bau.edu.jo

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discussing the various options. Different types and sizes were tried, a Gellhorn pessary was inserted, and the woman was comfortable and able to retain it. The woman was advised to attend follow-up after 3 months. Unfortunately, she did not. She presented complaining of the passage of minimal feculent vaginal discharge 5 months after insertion. A pelvic examination was performed and showed a rectovaginal fistula (RVF). Conservative management was chosen. After 2 months, the RVF healed completely. VSDs are commonly used in the management of POP and very rarely lead to the development of RVF, mostly in neglected cases. While surgery is most often used to treat RVF, conservative management is very rarely adopted and may be considered in selected cases.

Introduction

This case report details the occurrence of a rectovaginal fistula (RVF) as a rare complication in the non-surgical management of pelvic organ prolapse (POP) using a Gellhorn pessary in a 72-year-old woman. The migration of the pessary led to the formation of an RVF, which presented with feculent vaginal discharge. The patient chose conservative management. Remarkably, the RVF completely healed within 2 months, highlighting the efficacy of this approach. The case underscores the necessity of vigilant follow-up and awareness of potential complications associated with vaginal support devices (VSDs) for POP. The available data do not define an optimal treatment.

Case Report

A 72-year-old diabetic and hypertensive woman presented with a 5-year history of symptomatic stage III POP. Following discussion, the woman opted for non-surgical management. Thereafter, a Gellhorn pessary was inserted.

The woman was advised to come back for a follow-up after 3 months; unfortunately, she did not. 5 months after insertion, she complained of the passage of minimal feculent vaginal discharge. Examinations showed that the knob of the pessary migrated through the posterior vaginal wall causing an RVF that was 0.8×0.8cm and located 4 cm proximal to the hymenal ring. The ring was removed.

Following a discussion with the patient, she opted for conservative management. Therefore, she was prescribed oral antibiotics (Amoxicillin/Clavulanic acid 500 mg and Metronidazole 500 mg, both twice daily for 2 weeks), topical estrogen cream (Oestardial 0.1% vaginal application twice daily for 2 weeks, then twice weekly for 6 weeks) and stool softeners (a combination of polyethylene glycol sachet and lactulose syrup 10 mL, both twice daily for 2 weeks). The woman was followed up biweekly, and examination showed a progressive reduction in the size of the RVF. After 2

months, the fistula healed completely. We asked the patient for permission to take photographs of the trauma at the time of the diagnosis and the fistula at the subsequent follow-up visits, but she declined. The patient is still under our care for the management of the overactive bladder symptoms that significantly improved, and she attends the clinic every 3 months. No further treatment for the POP was offered.

Discussion and Conclusions

RVF is always pathological. Causes may include trauma such as childbirth injuries or foreign bodies, inflammatory bowel disease, pelvic cancer, radiation, or pelvic surgeries.¹ VSDs are employed in the management of POP. Their use is safe, tolerable, and effective in relieving symptoms of POP.² The success rate of VSD is between 56% and 89%.³

VSDs are foreign objects, and their placement may cause pressure that affects the vaginal wall. Therefore, adequate follow-up is necessary to ensure proper fitting and integrity of the vaginal wall.⁴ Potential complications associated with their use include vaginal erosions, adhesions, bleeding, and, very rarely, the formation of a vesicovaginal fistula and RVF.⁴

POP is prevalent and has a negative impact on quality of life. Treatment options include the use of a VSD or surgery.⁵ VSDs may be suggested for women who are on the waiting list for surgery, for the treatment of recurrent POP or prolapse developing during pregnancy, and for women who have significant co-morbidities. The practice of fitting VSDs needs training.⁵ Therefore, appropriate knowledge among healthcare practitioners of the different types of VSDs is necessary to provide better care for women who require VSDs.

The most frequently used VSDs are ring and Gellhorn pessaries. Additionally, the rare complications associated with their use include RVS, vaginal impaction, and vaginal evisceration of the small bowel through the vaginal vault.⁶ Additionally, several case reports have been published about RVF that developed after the use of a VSD. In particular, the use of a Gellhorn or shelf pessary where they were neglected for variable periods of time, and clinical follow-ups were delayed more than 3 months.⁷

The diagnosis of RVF is most often clinical. This will enable the classification into simple or complex depending on their size, location, and etiology.⁸ While no additional investigations are usually required to confirm the diagnosis, in the case of high or complex fistulae, imaging studies such as magnetic resonance imaging may be indicated.⁷

The treatment and prognosis of RVF require an understanding of the different underlying pathological mechanisms and also the characteristics of the fistula, such as number, site, size, and patients' factors, such as serious co-morbidities.¹ Current literature describes various treatment options and surgical approaches. The available data do not define an optimal treatment. Medical treatment is usually required initially to control the local infection. This

may include antibiotics, sitz baths, stool softeners, and antibiotics.

Surgical management is the most frequently adopted treatment option. Furthermore, the choice of surgical approach is usually based on the etiology and the location of the RVF, whether high or low. The approaches for surgical repair are either transvaginal or abdominal, and the success rate of both abdominal and local approaches is around 82.5%. Additionally, fecal diversion may be required for complex fistulae.⁷

Our case report describes the successful conservative management of RVF, which is a rare management approach supported by other published reports that showed that conservative management is more successful if the size of the RVF is smaller than 1 cm and with the use of antibiotics.⁹ Additionally, the treatment included the use of topical estrogens and stool softeners to promote healing.^{9,10}

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