Most rectovaginal fistulas are acquired although congenital abnormalities do exist. The acquired fistulas include etiologies such as trauma (including operative, obstetric, and traumatic injuries), infection, inflammatory bowel disease, carcinoma, and radiation. ***Toglia (2010)***

Welton (2010) stated that depending on the size and location of the fistula, you may have very minor symptoms or significant problems with continence and hygiene. Signs and symptoms of a rectovaginal fistula may include:

- Passage of gas, stool or pus from the vagina
- A foul-smelling vaginal discharge
- Recurrent vaginal or urinary tract infections
- Irritation or pain in the vulva
- Pain during sexual activity
- Rectal itching and bleeding
- Symptoms & signs of pelvic inflammatory disease

Rectovaginal fistula RVF diagnosed by Physical Examination also Imaging Studies have important role in the diagnosis as proctography, vaginography, Barium enema, Computed tomography (CT), Endoanal sonography and Magnetic resonance imaging (MRI) ***Dana (2009)***

Hyperbaric oxygen is a safe, effective, and well-tolerated treatment for radiation-induced soft tissue necrosis. ***Williams, et al (1992)***

The authors stated that “the Noble-Mengert-Fish operation is effective for primary and recurrent or persistent rectovaginal fistulas. The circumanal surgical exposure permits concomitant repair of all perineal defects. ***Veronikas, et al (1998)***

Excision of rectovaginal fistula with reinforcement of rectovaginal septum using Vypro mesh is safe and reliable. Postoperative erosions and recurrences are possible serious inevitable complications. ***Khaled, et al (2010)***

Sonoda, et al (2002) stated that some surgeons preferred the transperineal approach and included sphincteroplasty as a component in the repair. There are 2 possible explanations for the discrepancy in success rates.

First, the experience of the surgeon may play a significant role in the outcome.

Second, the addition of the anal sphincteroplasty aids in restoring the normal "high-pressure" zone of the anal canal allowing for improved physiological function**.**

In summary, the use of a mucosal advancement flap repair is appropriate for most simple rectovaginal fistulas. Its success rate depends on the etiology of the fistula, with a better outcome in patients with obstetrical injuries than patients with inflammatory bowel disease. It also depends on previous repairs, with a higher failure rate in patients who have undergone two or more attempts, and it depends on the preoperative assessment of sphincter function, with patients undergoing sphincter repair having a higher success rate with mucosal advancement flaps. ***David, et al (2007)***

However, our initial experience with allografts in prolapse repair has been encouraging and the indications for their use have increased. To our knowledge, this is the first report of the use of an allogenic cadaveric graft in the successful repair of a recurrent rectovaginal fistula. A greater number of cases using cadaveric dermal grafts in recurrent rectovaginal fistula repairs are needed before they can be recommended over the traditional autologous flaps. ***Miklos and Kohli (1999)***