Rectovaginal fistula (RVF) is an abnormal epithelial lined communications between the wall of the rectum and the posterior vaginal wall. ***Tsang and Rothenberger (1997)***

The incidence of RVF is low and accounts for about 5% of all anorectal fistulas. ***Tsang and Rothenberger (1997)***

RVF is a socially and psychologically harmful condition affecting a number of women worldwide. It was first reported by Hippocrates in 430 BC, who described the placement of a Seton for management of this condition. ***Adams (2007)***

The rectovaginal septum is the thin septum separating the anterior rectal wall and the posterior vaginal wall. The caudal portion of the septum is the perineal body. The anal sphincters are located in the posterior portion of the perineal body. The transverse perinei muscle traverses the perineal body and is often used in anal sphincteroplasty and rectovaginal fistula repair. ***Dana (2009)***

The most common etiology for RVF is traumatic in origin, and probably for all RVFs, is obstetric injury. Other etiologies for RVF include radiation injury, inflammatory bowel disease (IBD), most often Crohn's disease, operative trauma, infection, congenital and neoplasm. ***Dana (2009)***

Most patients with RVF report the passage of flatus and/or fecal material through the vagina. Patients may also report recurrent vaginitis, foul smelling vaginal discharge, or persistent vaginal bleeding. ***Nichols (1996)***

During physical examination, the perineum is inspected for perineal skin, perineal body, discharge, ulcer and any swelling present. ***Nichols (1996)***

A digital rectovaginal examination palpating for masses, scarring, and presence of a fistula tract. Inflamed mucosa, suspicious ulcers, or masses should be biopsies. Fistulas that are smaller in size or higher in the vagina are diagnosed by speculum examination using a Sim's retractor or half of a bivalve speculum. If a fistula is not detected by these maneuvers, proctoscopy and/or examination under anesthesia should be considered. ***Nichols (1996)***

Barium enema is useful for identifying fistulas especially in inflammatory bowel diseases. A computed tomography scan (CT) of the abdomen and pelvis may also be helpful. ***Stoker, et al (2002)***

Recently, coronal magnetic resonance imaging (MRI) has been evaluated as a good diagnostic tool for RVF. ***Dwarkasing, et al (2004)***

RVFs may be managed both medically and surgically, with the latter being the preferred option. A number of different surgical techniques used in closure of Rectovaginal fistula RVF. ***John, et al (2008)***

Much controversy surrounds the optimal timing of surgical repair of RVF. However, operative intervention should be delayed until there is complete resolution of any infection as fistulas may close spontaneously. Some small fistulas will close spontaneously and, therefore, several authors recommend waiting 6 to 12 weeks before attempting repair. ***Toglia (2001)***

However, other authors have demonstrated good results with repair of RVF in the immediate postpartum period. ***Hankins, et al (1990)***

Important surgical principles for closure of a RVF include wide mobilization of tissue, excision of the fistula tract, meticulous hemostasis, closure in multiple layers without tension, and adequate blood supply to enhance healing is a golden aim. If adequate blood supply is not present, transposition of the

bulbocavernosus fat pad (if operating vaginally) or omentum (if operating abdominally) is strongly recommended. Adherence to these basic principles will greatly aid in the success of the surgery. ***Novi and Northington (2005)***