LAPAROSCOPIC RESECTION OF A SIGMOID COLO - VESICAL FISTULA

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ABSTRACT
Colo vesical fistula can be a result of a variety of conditions. Patients commonly present with lower urinary tract symptoms (LUTS) and recurrent urinary tract infections (UTI). The management is surgical resection. Urinary and faecal diversion may be considered in advanced cases whereas infliximab is used to treat fistulating Crohn’s disease. Here the surgery was performed laparoscopically which contributed to minimal analgesic requirement, early mobilization and early discharge.

INTRODUCTION: Acquired colo vesical fistula can result from a variety of pathologies. The commonest is secondary to diverticular disease and the others are malignancy, Crohn’s disease, actinomycosis and radiation injury⁴. Patients commonly present with lower urinary tract symptoms (LUTS), recurrent urinary infections. The management is surgical resection, which if performed laparoscopically results in less morbidity⁴.

Case report: A 65 years old otherwise healthy male had presented to a local hospital with storage predominant LUTS for 3 months duration and was investigated and treated at a urology clinic for a culture positive cystitis. He developed three episodes of cystitis despite adequate antibiotic therapy and medication to improve bladder outflow obstruction. Later he had experienced passage of air through urethra during micturition. Cystoscopy, colonoscopy and contrast enhanced computer tomography of the abdomen were performed which revealed a colo-vesical fistula from mid sigmoid to the dome of the bladder due to sigmoid diverticulosis⁴.

He underwent a laparoscopic segmental resection of sigmoid colon with excision of the fistula with a cuff of the bladder. Intra corporeal end to end stapler anastomosis of the sigmoid colon without defunctioning stoma and an intra corporeal suturing of the bladder were performed.

KEYWORDS: colo vesical fistula, diverticular disease, pneumaturia, recurrent cystitis, laparoscopic resection.
The patient’s post operative period was uneventful. He was mobilized, started on oral liquids on the following morning and was on normal diet by day 3. Pain was managed with epidural bupivocain on day one and subsequently with oral analgesics. He was discharged on day five and Foley’s urinary catheter was left for 14 days and patient is asymptomatic at present.

Histology revealed diverticular disease with colo vesical fistula formation.

DISCUSSION
Colo vesical fistula is an uncommon condition in which there is an abnormal connection between colonic mucosa and the urothelium of the bladder. This condition can be congenital when it develops from abnormalities of the uro rectal septum and is associated with imperforate anus.\(^5\) In acquired cases colonic or bladder malignancies and Crohn’s disease and diverticular disease should be considered. Urinary contamination with colonic flora results in uro sepsis which may be life threatening in immune compromised patients.

Although there are literature about conservative management and total endoscopic management, resection of the fistula with reconstruction of intestinal and bladder integrity is the main treatment for colo vesical fistula. Urinary and faecal diversion may be considered in advanced cases\(^6\) whereas infliximab is used to treat fistulating Crohn’s.\(^6\)

In the patient discussed the surgery was performed by laparoscopy. He had minimal analgesic requirement, early mobilization and early discharge.

CONCLUSION
Sigmoid resection and bladder repair for colovesical fistula can be performed laparoscopically with resultant reduced morbidity.

REFERENCES