

## Editorial

Open Access, Volume 1

# Vestibular anus, a surgical dilemma

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Received: Sep 13, 2021

Accepted: Oct 12, 2021

Published: Oct 19, 2021

Archived: www.jjgastro.com

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## Editorial

It is a pleasure for me to draw attention in this issue of your admirable journal to recto-vestibular fistula. Vestibular anus means congenital presence of the anus in the vestibule behind the vaginal orifice. It shares a common wall between the vagina and the rectum. In addition to an abnormal cosmetic appearance, it leads to recurrent attacks of urinary tract and vaginal infections. In adult female patients, it leads to dyspareunia. Several techniques have been described for the treatment of this type of anomaly, however; the postoperative continence is not always satisfactory. Optimal surgical repair would be easy to assess minimum dissection to spare pelvic nerves and guide the rectal pouch through the muscles of continence and intact sphincter [1]. The surgeon must cautiously during surgical separation of the posterior vaginal wall from the anterior rectal wall to avert rectal wall tear.

Posterior sagittal anorectoplasty (PSARP) is arguably the standard approach for rectovestibular fistula repair based on the extensive work of Pena and Levitt over the past 3 decades [2]. Okada and his colleagues design anterior sagittal anorectoplasty (ASARP) for repair of AVF [3]. Both approaches PSARP and ASARP with or without colostomy, involved division of the levator muscles and muscle complex (the main components of the continence mechanisms), the perineal body, and the perineal skin [4]. This may be associated with wound complications like the scar of the perineal skin bridge between the fistula and the new anus, also, wound infection, wound dehiscence with fibrosis, sub-cutaneous leak, skin suture dehiscence, pelvic

floor descent, anal stenosis, rectal prolapse, recurrence of fistula, soiling, incontinence, constipation and unsatisfactory cosmetic outcome [5]. This complication can be avoided by trans-sphincter ano-rectoplasty (TSARP). It was reported by Akshay et al, 2007 [6]. It preserves an intact perineal skin bridge without skin incision; eliminates the risk of wound problems; results in a better aesthetic result due to lack of an incision and scar, also the external sphincter complex and levator muscle are identified but not divided. Perineal or posterior sagittal incisions are not utilized, and therefore the perineal body and neurovascular supply are not disturbed [7]. Described ASARP with external anal sphincter preservation and passing neorectum in the middle of a muscle complex by make midline skin incision extending from the ectopic opening to the putative anal site. However; this approach is associated with perineal scarring and don't add a new to the previous approach TSARP.

From my experience, all surgical techniques are suitable for repair of vestibular fistula but TSARP is the best approach regarding to fecal continence and cosmetic appearance. We just finished a study about the recto-vestibular fistula and I will publish it in the near future. Our study is unique because, to the best of our knowledge, it is the only study to compare the outcomes obtained by the treatment of vestibular fistula using four different operative techniques: Trans-Sphincter Anorectoplasty (TSARP), classic Anterior Sagittal Anorectoplasty (ASARP), modified ASARP, and posterior sagittal anorectoplasty (PSARP). We published before one study about TSARP [8].

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