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SURGICAL TECHNIQUE

York-Mason repair of recto-urethral fistula

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Introduction

Recto-urethral fistulas (RUF) are difficult to diagnose and to treat. The methods of treating chronic RUF are very different from the management of complicated RUF associated with either severe sepsis or radiation-damaged tissues.

For non-complicated RUF, we recommend systematic placement of an indwelling bladder catheter and antibiotic therapy as the initial steps. If the fistula fails to close, we recommend the York-Mason technique for repair of RUF, whether it is of postoperative, inflammatory, or post-traumatic origin.

Prior to performing the York-Mason repair, the fecal stream should be diverted by a proximal colostomy. If not, teams, who do not perform diverting colostomy, recommend preoperative mechanical and antibiotic bowel preparation.

Diagnosis of RUF

Diagnosis may be based on clinical presentation (passage of urine through the anus), fistula visualization by cystoscopy or colonoscopy, or radiologic delineation of the RUF by pelvic MRI with rectal opacification.

Necessary equipment

The operating table should allow the patient to be positioned in prone jack-knife position with all necessary supports and gel pads to prevent pressure.

Surgical instruments should include a scalpel with a #23 blade, DeBakey forceps, Barraya forceps, and toothed forceps, Mayo and Metzenbaum scissors, a self-retaining Parks retractor, Farabeuf right angle retractors, and absorbable 2-0 and 3-0 sutures.

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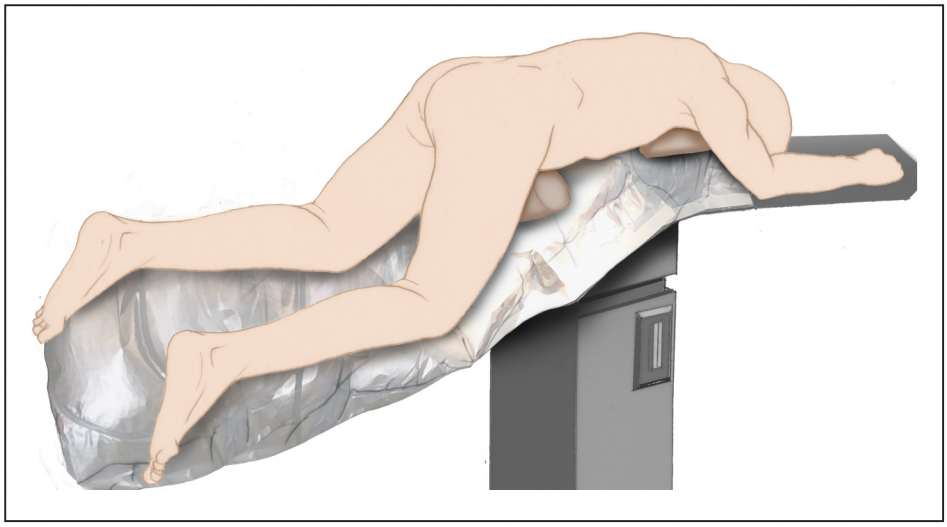

1 Patient positioning

After insertion of a Foley indwelling bladder catheter, the patient is placed in prone jack-knife position to enable a posterior approach to the rectum. A warming blanket is placed beneath the patient and over the upper half of the body.

2 Skin incision

The typical incision is placed in the posterior midline below the coccyx, but variations, such as an oblique incision have been described.