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SURGICAL TECHNIQUE

Using acellular dermal matrix during transanal repair of rectourethral fistula: Surgical technique

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Rectourethral fistula;
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Introduction

Management and reconstruction of complex rectourethral fistulae are one of the most difficult problems to deal with. Most causes are either traumatic or iatrogenic (treatment of localized prostate cancer, urethral surgery, rectal surgery and radiotherapy) [1]. The management of such complication varies between conservative management using urinary and/or stool diversion to operative management including primary closure with or without the use of grafts and interposition flaps. Many surgical approaches have been described including transabdominal, transperineal, transanal and transsphincteric [2]. After the closure of the fistula orifice, healthy tissue is commonly used for interposition. Many tissues have been used including omentum, buccal mucosa, gracilis muscle or a dartos flap [2,3]. The choice of the surgical technique depends not only on surgeon preference but location and size of the fistula, concurrent urethral stricture disease as well as the presence of irradiated tissue [4].

The acellular dermal matrix is characterized by being less inflammatory and has less potential in generating an immunological response [5]. It has been used in many types of reconstructive surgeries including breast reconstruction, diabetic foot reconstruction, gingival reconstruction and post burn dermal reconstruction.

Here we describe our transanal repair of a rectourethral fistula post radical prostatectomy using acellular dermal matrix as interpositioning material.

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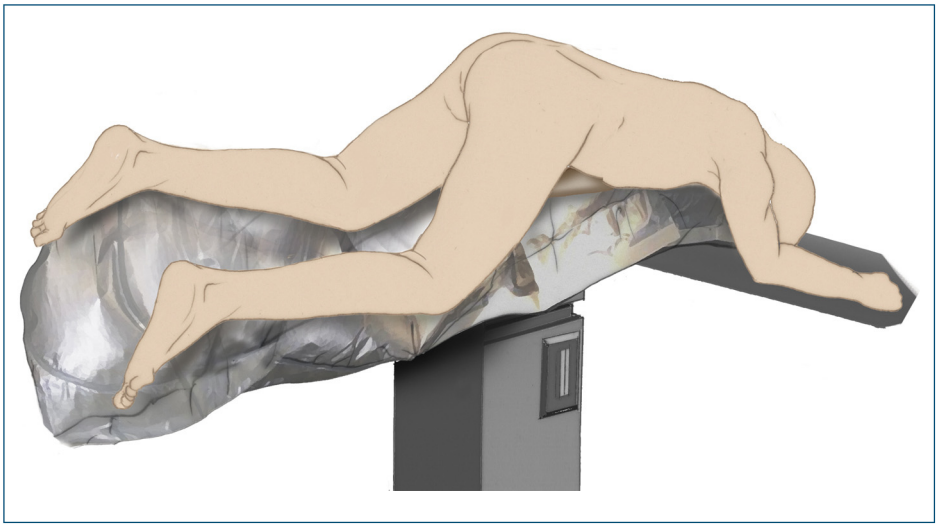
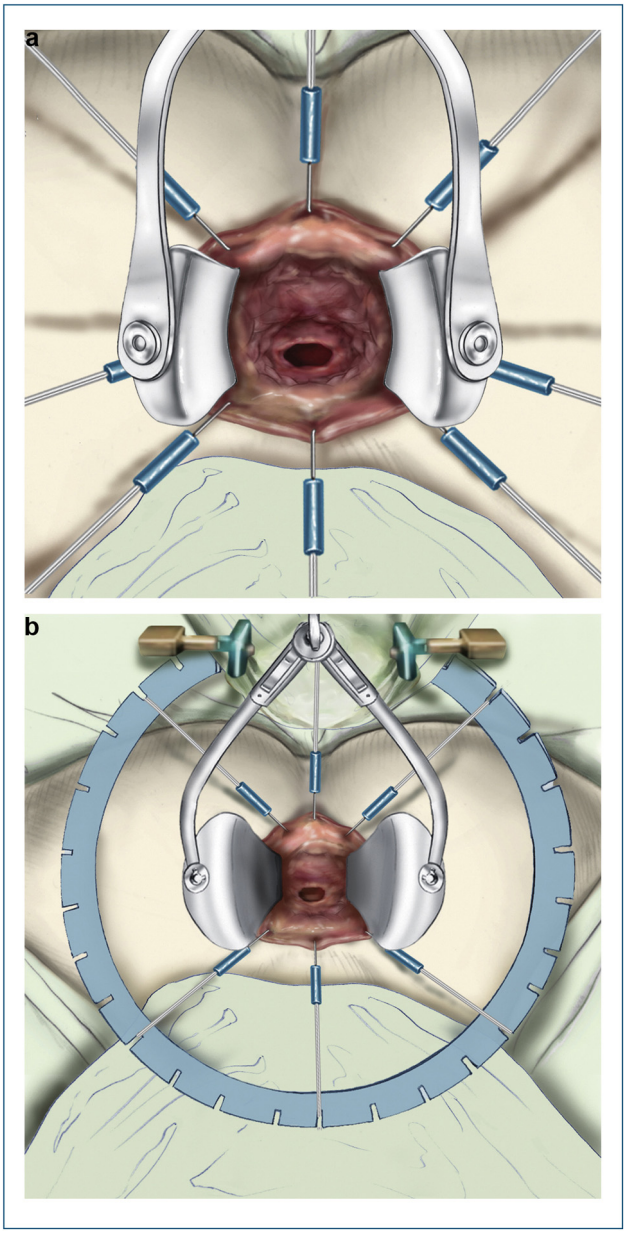
1 Patient positioning

After an endotracheal intubation and then placement of a urethral catheter, the patient is placed in the Jack-knife position.



2 Identification of the fistula orifice

We used a Lone Star and Parks' anal retractor. The fistula orifice is identified in the anterior rectal wall.



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