

Treatment of Vestibular Fistulae

Vestibular fistula is by far the most common [anorectal malformation](#) in females. The most important and conspicuous characteristic of this defect is the fusing together of the anterior (front) wall of the rectum and the posterior (back) wall of the vagina into a single common wall.

About 95% of patients we operate on to repair vestibular fistulas have voluntary bowel movements by the age of three. Only those who have a very unusual, poorly constructed sacrum (the lower part of the spine that forms part of the pelvis) or some other severe malformation have no bowel control. That means that a child born with [vestibular fistula](#) has an excellent prognosis and represents the typical pediatric surgical case of a baby born with a single malformation and when treated correctly, can have reconstruction of the anatomy to help make her functional and socially accepted.

Surgeons must be aware that the most important anatomic feature is the common wall between rectum and vagina and must learn to separate those two structures without making holes in either one. In addition, surgeons should identify the sphincter mechanism and be sure to put the rectum within the sphincter mechanism. A complication, such as infection or an opening of the surgical wound, is unacceptable since it may change the final functional prognosis in these patients.

With or Without a Colostomy

A [colostomy](#), an operation to create an artificial anus (stoma) to allow feces to pass out of the body and into a stoma bag, gives the patient maximum protection. The tendency of pediatric surgeons at the present time, however, is to perform colorectal repairs in a single stage without a colostomy. We think that is a very good trend, but should be done carefully and honestly.

There is no question that vestibular fistulas can be repaired in the neonatal period and without a colostomy by a delicate, fine, scrupulous, meticulous, and neat surgeon. For surgeons who have not had much experience, it is much better to do a colostomy operation, particularly if the bowel is not well prepared or if the separation between the vagina and the rectum was not done meticulously and the repair is less than satisfactory. Some surgeons could do this repair in three stages:

1. colostomy
2. main repair of the vestibular fistula
3. [closure of the colostomy](#)



Other surgeons would use two steps, provided the bowel is clean, with the colostomy and repair at the same time, and the colostomy closure later. Still other surgeons would choose to do all the surgery in a single stage.

If a patient is born at Cincinnati Children's Hospital Medical Center and is in good health, we would personally prefer to perform a total repair of the vestibular fistula primarily without a colostomy. If the patient comes to the hospital several months after birth, already constipated, impacted, and with megasigmoid (a very dilated colon), we would most likely ask the parents for consent to do a colostomy and repair in the same stage. Depending on what we see when we begin the surgery and if the colon is perfectly clean, we might do the repair without a colostomy, insert a central line, and maintain the patient with potential nutrition and nothing by mouth for 10n days. If we have any doubts during the operation about doing the repair without a colostomy, we would instead opt for a colostomy.

Contact the Colorectal Center at Cincinnati Children's

For more information or to request an appointment for the Colorectal Center at Cincinnati Children's Hospital Medical Center, please [contact us](#).