Rectovesical fistula treated by glue injection plus endoclipping technique

A 74-year-old man was referred to our department for endoscopic evaluation and treatment of a rectovesical fistula. He had undergone prostatectomy for early prostate cancer 2 weeks previously. Postoperatively, he had developed pneumaturia and dysuria; computed tomography (CT) had revealed a rectovesical fistula.

At colonoscopy, a well-circumscribed opening of a fistula tract was seen in the anterior rectal wall, located 2 cm beyond the linea dentata (Fig. 1). The edges of the fistula were cauterized with argon plasma coagulation to stimulate an inflammatory reaction and local collagen synthesis. A 2-mL syringe containing 1 mL n-2-butyl cyanoacrylate (Histoacryl; B. Braun, Melsungen, Germany) and 1 mL Lipiodol was prepared and the glue/Lipiodol mix was injected via a 23-G variceal needle in aliquots of 0.5 mL at four sites of the wall of the fistula, followed by a flush of Lipiodol equivalent in volume to the dead space of the needle. The margins of the fistula orifice were brought into contact and closed with endoclips (HX-600-900; Olympus, Athens, Greece; Fig. 2). After endoscopic intervention, the patient was treated with parenteral nutrition and antibiotics. His symptoms completely resolved and he was discharged 7 days after the procedure. A follow-up endoscopy performed 1 month later revealed that the lesion was well healed (Fig. 3). He remains asymptomatic 6 months post-procedure. Rectal injury after radical prostatectomy with subsequent formation of rectovesical fistula has an incidence of 1–11% [1].

York–Mason, modified York–Mason and less invasive repair methods, which include laparoscopic and robotic-assisted techniques, have been reported as successful treatment modalities for rectovesical fistulas [2,3]. We wish to emphasize the use of the combination of endoclips plus n-2-butyl cyanoacrylate injection in the treatment of gastrointestinal fistulas. To our knowledge, the present case is the first report of a rectovesical fistula that was successfully treated with injection of glue plus endoclipping.

Endoscopy_UCTN_Code_TTT_1AQ_2AG

Competing interests: None

P. Katsinelos1, S. Gkagkalis1, G. Chatzimavroudis1, C. Zavos2, J. Kountouras2

1 Department of Endoscopy and Motility Unit, G. Gennimatas General Hospital, Thessaloniki, Greece
2 Second Department of Internal Medicine, School of Medicine, Aristotle University of Thessaloniki, Ippokration Hospital, Thessaloniki, Greece

References

Corresponding author
P. Katsinelos, MD, PhD
Department of Endoscopy and Motility Unit G. Gennimatas General Hospital
School of Medicine, Aristotle University of Thessaloniki
Thessaloniki
Greece
Fax: +30-2310-963341
gchatzimav@yahoo.gr

Fig. 1 Endoscopic view of the orifice of a fistula located in the anterior rectal wall 2 cm from the linea dentata.

Fig. 2 View during the endoscopic procedure to close the fistula using a glue injection plus endoclipping showing complete closure of the orifice of the fistula with the use of six endoclips.

Fig. 3 View during an endoscopy performed 1 month later showing that the fistula is well healed and that some residual clips remain in place.