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Figure 1. CT of the abdomen with intravenous and intravesicular contrast (axial view) showing contrast extravasation from the bladder tracking toward the rectum (arrow).

Figure 2. CT of the abdomen with intravenous and intravesicular contrast (sagittal view) showing inflated Foley catheter balloon within the bladder (black arrow), multiple areas of contrast extravasation from the bladder (diamonds), and contrast filling the rectum (white arrow).

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A 56-year-old man presented for decreased urine output into his Foley catheter and diarrhea for 24 hours. He had undergone end colectomy with colostomy and partial cystectomy 4 weeks before for stage IV rectal adenocarcinoma. Physical examination showed mild suprapubic tenderness. WBC count and renal function results were normal. A computed tomography (CT) cystogram was obtained (Figure 1 and 2).

For the diagnosis and teaching points, see page 520.
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DIAGNOSIS:

Rectovesical fistula. The most common causes of rectovesical fistula are malignancy and inflammatory conditions such as diverticulitis and Crohn's disease. Fistulas may also be caused by trauma, surgery, bladder stones, or pelvic radiation.[1] Gouverneur's syndrome, the constellation of tenesmus, urinary frequency, dysuria, and suprapubic pain, should suggest the diagnosis.[2] Most patients present with recurrent urinary tract infections and pneumaturia or fecaluria.[3] Passage of urine per rectum occurs in 15% of cases.[3] Detection of charcoal or poppy seeds in the urine after an oral challenge can confirm the diagnosis.[3]

The imaging modality of choice is CT scan of the abdomen and pelvis with intravenous contrast, with sensitivity of 60% to 100%.[3] Cystoscopy and colonoscopy are less sensitive but may demonstrate the cause of the fistula.[3] Most patients require surgical repair, although a trial of conservative management with Foley decompression of the bladder may be attempted.[3]

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