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VISCERAL SURGERY VIDEOS

Martius advancement flap for low rectovaginal fistula (with video)



Lambeau de Martius pour fistule rectovaginale basse (avec vidéo)

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The Martius flap is a technique used especially in the treatment of low rectovaginal fistula. This technique corresponds to an interposition of a muscular flap, harvested at the level of the large lip, and placed in the rectovaginal septum. It is an infrequent but reproducible surgical procedure associated with low morbidity and a success rate above 60% [1,2,3]. This video shows a 34 year-old woman presenting with a low rectovaginal fistula observed after vaginal delivery with perineal tear. This fistula was persistent after a first management corresponding to a direct repair. In this situation, several techniques may be used. However, in this patient with absence of sphincter involvement, small fistula diameter, and the absence of local infection, we decided to perform a Martius flap. The use of a temporary stoma is not routine in case of patients with pauci-symptomatic fistula without major functional repercussion, and in absence of local suppuration. The procedure began with a transverse perineal incision of the anovulva raphe, with dissection of the anovaginal and rectovaginal septum until at least 3 cm after the fistula (Fig. 1). The dissection should be careful and conducted ahead of the sphincter in order to not damage it. The rectal and vaginal fistulous defects were then dissected with excision of edges of the 2 orifices leading to suture in well vascularized tissues. The procedure was followed by repairing the rectum and the vagina by stitches of Vicryl® 3/0 (Fig. 2). The second step of the procedure corresponded to the flap creation using the left bulbo-cavernosus muscle (Fig. 3). A labial incision was performed on the large left lip allowing to identify this muscle without damaging its vascular pedicle located at its lower part. Subcutaneous dissection was then performed to allow the passage of the flap between the two skin incisions with interposition of the muscle between the rectal and vaginal sutures and fixation using stitches of Vicryl® 3/0 (Fig. 4). In this patient, it was possible to make an additional

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Figure 1. Dissection of the anovaginal and rectovaginal septum.

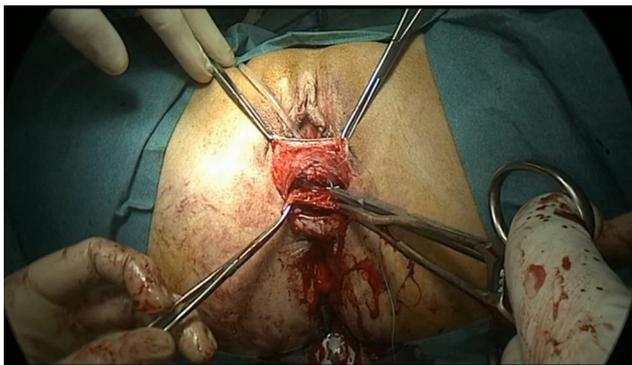


Figure 2. Repair of the rectum.



Figure 3. Dissection of the left bulbo-cavernosus muscle.

excision of the lower part of the vagina (including the vaginal defect) to potentially decrease the risk of recurrence. However, this vaginal excision is not routine because not always feasible and potentially associated with more

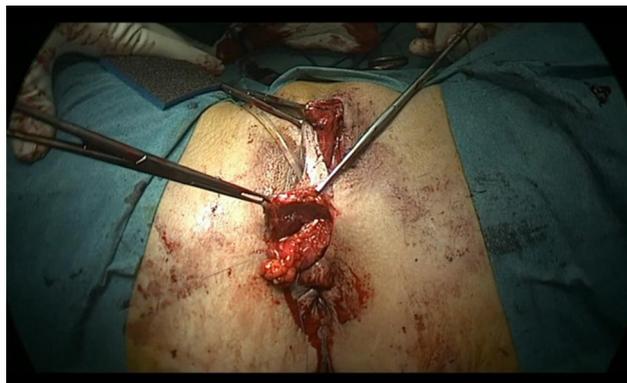


Figure 4. Interposition and fixation the flap in the rectovaginal septum.

tissue-damaging. The perineal incision was closed by loose subcutaneous stitches of Vicryl® 4/0 and the labial incision by cutaneous nonabsorbable sutures. The labial incision was drained using a ManoVAC. There was a need for 3 times a day vaginal toilet during the postoperative period. This video shows the different steps necessary to follow to perform a Martius flap technique for low rectovaginal fistula management. It will be useful for all surgeons needing to perform this surgical management.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <https://doi.org/10.1016/j.jviscsurg.2019.06.016>.

Disclosure of interest

The authors declare that they have no competing interest.

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