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Meeting abstract

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Colovesical fistulae in the sigmoid diverticulitis

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Background

Colonic diverticular disease is common in developed countries, and its prevalence increases with age. Enterovesical fistula, is an abnormal communication between bladder and a segment of the digestive tract. Colovesical fistula is the most common type (65%) of fistula associated with colonic diverticular disease. Colovesical fistulae are well-recognized but relatively uncommon in the surgical practice. As a result, few centers have sufficient experience in the investigation and surgical treatment of colovesical fistulae to develop clear protocols in its management. This study analyzes our experience in the treatment of patients with diverticulitis complicated by fistula formation in order to assess the appropriate management. Patients with neoplastic or iatrogenic colovesical fistulae were excluded from this study.

Materials and methods

We report the clinical cases of 2 patients with colovesical fistulae observed in our Surgical Department, one with elective surgery and the other one with emergency surgery. Both patients had a history of urological symptoms. In the first case, a barium enema was performed and it showed a sigmoid diverticular disease but not the presence of a colovesical fistula. A cystoscopy was then performed and it shows the presence of a fistula and cystitis. A pelvic CT was necessary to achieve a staging of diverticulitis. In the second case, CT showed a large amount of pus in the pelvic pouch, and several adherences involving the great epiploon, part of the sigmoid intestine and the bladder. In both cases we performed a sigmoid resection with a primary anastomosis together with a small vesical window ectomy and placing a Foley catheter for about 10 days in the elective surgery and 14 days in the emergency surgery.

Results

The most frequent signs and symptoms were fecaluria, pneumaturia, dysuria, hematuria and chronic abdominal pain in hypogastric and left iliac regions. Pneumaturia and fecaluria were only present in the patient who underwent elective surgery. In the first case, the fistula was detected by cystoscopy, in the second case, treated in emergency surgery, and the diagnosis was obtained by surgical exploration. In both cases the postoperative course was uncomplicated and there were no anastomotic leaks and no deaths.

Conclusion

The diagnosis of colovesical fistula is predominately clinical, as many of the patients complain of urological symptoms. However, cystoscopy is the most accurate test to detect fistulae, followed by barium enema. Colonic endoscopy and CT are the most reliable means of excluding a colonic malignancy. Besides CT allows achievement of a staging of diverticulitis disease. Cystoscopy, barium enema, colonic endoscopy and CT should be routine in the investigation of colovesical fistulae.

Surgery is the only treatment that assures cure and avoids relapses. Resection and primary anastomosis should be

the treatment of choice for colovesical fistulae, with an acceptable risk of anastomotic leak and mortality.

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