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(Case Report)

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Spontaneous Urethro sigmoid fistula: A rare case

Ayoub Ballouki *, Oussama Benabdelhak, Rhyan Ouaddane Alami, Mustapha Ahsaini, Soufiane Mellas, Jalal Eddine Ammari, Mohamed Fadl Tazi and Mohammed Jamal El Fassi

Department of Urology, Hassan II university hospital, Fes, Morocco.

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Abstract

Urethro sigmoid fistula is an uncommon entity, which is diagnosed often by fecaluria . It is mostly iatrogenic: prostate surgery or rectum surgery, radio induced (radiotherapy) [1]. In our case, our patient is 73 years old, he came to the emergencies for a left renal colic, and some urinary symptoms especially the passage of urines through the anus. the Abdominal CT (excretory phase) showed a left ureteral pyelocalicial dilation above an ureteropelvic stone which size is 6 mm and a fistula between the urethra and the sigmoid. The treatment was a supra pubic cystostomy and a colostomy for 3 Months. the cystography of control showed the absence of communication between the prostatic urethra and the colon sigmoideum.

Keywords: Bladder; Sigmoid; Urethro Sigmoid Fistula;

1. Introduction

In our case, we had a 73 years old patient.

He was married, father of three kids, and a farmer. in his medical history: he had benign prostatic hypertrophy treated by alpha blockers, diffuse large B-cell lymphoma (treated by chemotherapy).

He kept the urinary catheter 3 weeks, and has been treated by alpha blockers. He was controlled in the urology consultation, a trial of void has been successful, the debimetry showed a voided volume (450 ml), maximum flow rate was 16 ml / s.

The post void residual urine was negligeable. A control was programmed 3 months, then 2 months later, the patient came to the emergencies for a left renal colic and passage of urines through the anus. He was afebrile. In the abdominal examination: there was a hypogastric and left lumbar tenderness. In the biological assessement : there was a hyperleukocytosis (16 000 wc/mm***3*** with a predominance of neutrophils 12000/mm3), high CRP (C Reactive protein : 180 mg /L), a normal kidney function.

The abdominal CT (excrectory phase) showed a fistula between the prostatic urethra and the sigmoideum. There was also a 7 mm left pelvic ureteral stone responsible for uretero hydronephrosis.

The patient had a suprapubic catheter, a double J stent in his left kidney cavities, and a colostomy.

The clinical evolution and the biological assessement were satisfying. Hospital stay was 3 days.

His ureteral stone was treated one month later by rigid ureterocopy.

* Corresponding author: Ayoub Ballouki

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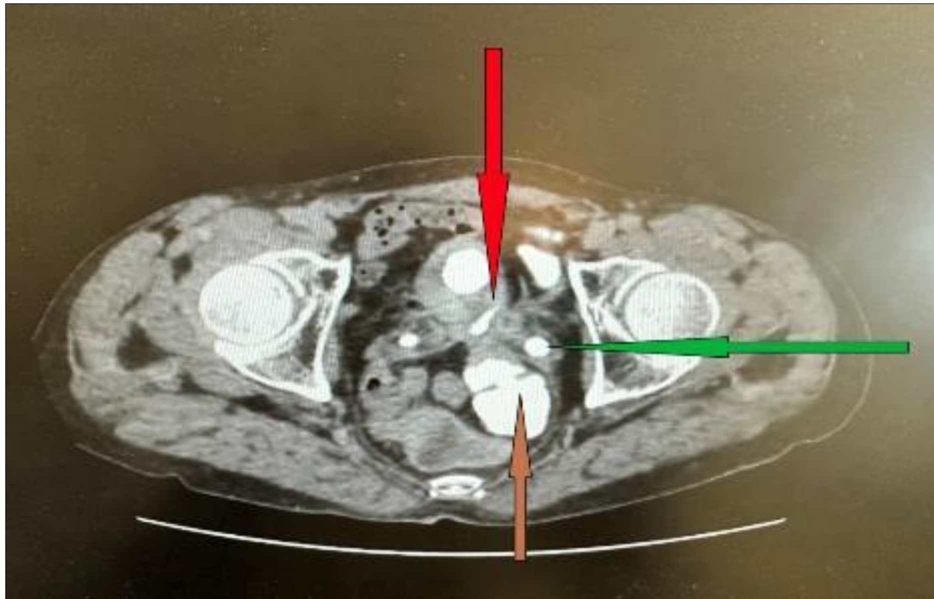
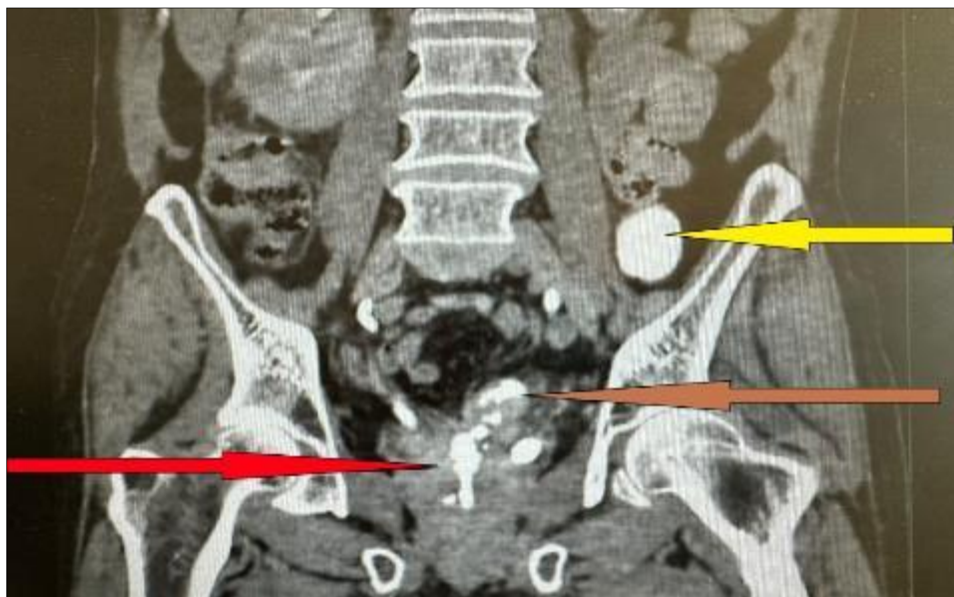
The patient had a cystography control after 3 months, it hasn't shown a communication between the urinary tract and the colon.



Red arrow: fistula between prostatic urethra and sigmoid; **Green arrow**: left pelvic ureter ; **Brown arrow**: sigmoid

Figure 1 Axial CT scan through the pelvic level (excretory phase) showing the communication between the prostatic urethra and the sigmoid



Brown narrow: sigmoid; Red narrow: fistula; Yellow narrow: descending colon

Figure 2 Coronal CT scan through the abdomen (excrectory phase) showing a fistula between the prostatic urethra and the sigmoid

2. Discussion

Urethro sigmoid fistula is an uncommon entity, most of the time iatrogenic[1]. In our case, our patient has never been operated, or irradiated. He was treated for a benign prostatic hypertrophy by alpha blockers. Our hypothesis was the

occurrence of a traumatic catheterization while inserting the indwelling bladder catheter through the urethra which we've confirmed after a deep interrogation with our patient who felt at the time urine leakage through his anus .

Multiple procedures can be proposed to the patients, but every situation should be analyzed to propose the appropriate treatment [3].

A literature review showed that the success of surgery, is attached to the absence of some risk factors: pelvic surgery and pelvic irradiation. In a case series of 30 patients, Al-Ali and Al, had a cure rate at 46 % (by digestive derivation and urine catheter). If the control cystography after 3 months is normal, a restoration of the bowel continuity is performed [5]. If the conservative treatment has failed, we can suggest other approaches by putting some flaps (muscular flaps for example) [2]. There is different surgical approaches: transanal, abdominal and transperineal. Some rules should be respected : we should excise the fistula until viable tissue, and the two walls (digestive and urinary) should be sutured and separated by putting a flap between them (to ensure tissue cicatrization and preventing recurrence) [4].

3. Conclusion

Urethro sigmoid fistula is a rare entity, there is no concensus in treating the urethro sigmoid fistula, every situation should be managed individually. Different authors shared their experience in some isolated cases.

More studies should be performed to establish the right recommendations to manage this pathology.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

Statement of ethical approval

If studies involve use of animal/human subject, authors must give appropriate statement of ethical approval. If not applicable then mention 'The present research work does not contain any studies performed on animals/humans subjects by any of the authors'.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

References

[1] Rectourethral fistulae: Diagnosis and management. Review of the literature E. Lacarrierea, L. Suaud b, R. Caremel a, L. Rouachea, J.-J. Tuechb, C. Pfister a, 2011

[2] Spahn M, Vergho D, Riedmiller H. Iatrogenic rectourethral fistula: perineal repair and buccal mucosa interposition. BJU 2008; 103:242—6. [37] Ulrich D, Roos J, Jaske G, Pallua N. Gracilis muscle

[3] interposition for the treatment of rectourethral and rectovaginal fistulas: a retrospective analysis of 35 cases. J Plast Reconstr Aesthet Surg 2009;62(3):352—6.

[4] Tazi K, El Fassi J, Koutani A, et al. The York-Mason pathway in the treatment of prostato-rectal fistulas. Prog Urol 2001; 11:1335—9.

[5] Al Ali M, Kashmoula D, Saoud IJ. Experience with 30 posttraumatic rectourethral fistulas: presentation of posterior transsphincteric anterior rectal wall advancement. J Urol 1997; 158:421—4.