ABSTRACT
The gold standard for management of rectovestibular fistula is a three-stage procedure in many Western countries. This malformation has been corrected successfully in a single-stage in the Indian subcontinent. This report describes a girl with rectovestibular fistula who was later diagnosed to be a case of congenital pouch colon (CPC).

Keywords: Anorectal malformation, Congenital pouch colon, Rectovestibular fistula.

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INTRODUCTION
Congenital pouch colon (CPC) is an abnormality where a pouch-like dilatation of a shortened colon is associated with an anorectal malformation (ARM). Diagnosis is usually made on an erect abdominal X-ray, which shows a large air-fluid level occupying >50% of the width of the abdomen. This malformation has frequently been reported in northern India. The sporadic cases have been reported from China, Sweden, Japan, and the UK. Based on the anatomic morphology of the pouch, the Saxena-Mathur classification differentiates CPC into five types:

Type 1: Ileum opens into the pouch colon (normal colon is absent).
Type 2: Ileum and cecum open into the pouch colon.
Type 3: Ascending and transverse colon open into the pouch colon.
Type 4: Normal colon with a recto-sigmoid pouch.
Type 5: Double pouch colon with a short interpositioned normal colonic segment.

CASE REPORT
A 2-year-old girl presented with an abnormally sited anal opening since birth. Hemogram, renal and liver function tests, and viral markers were normal. Radiographs of the chest and lumbosacral spine, and abdominal ultrasound were normal. She underwent a posterior sagittal anorectoplasty in January 2013. Following the procedure, she developed wound infection, causing a partial wound disruption. A rescue colostomy was planned in February 2013. However, during surgery the ileocecal junction and cecum were found in the left lower quadrant. The cecum has opening in a huge pouch (about 10 × 10 cm) behind the uterus. The pouch was devoid of colonic haustrations, appendices epiploicae, and had an aberrant blood supply. The ascending, transverse, and descending colon were absent. The uterus was infantile and both the ovaries were normal. There was a long Meckel’s diverticulum. A second (accessory) diverticulum is in the terminal ileum 10 cm distal to the Meckel’s diverticulum. Meckel’s and accessory diverticulum were excised along with a portion of intervening ileum. A double-barreled ileostomy and a tube pouchostomy were fashioned. A staged reconstruction was planned as the patient was weighing only 9 kg. A genitoscopy was done in June 2013. The urethra, bladder, bladder neck, and both the ureteric orifices were normal. A normal vagina and cervix uteri were seen. The neo-anus was dilated daily with #10 Hegar’s dilator. Daily pouch irrigations with normal saline were given via three-way Foley’s catheter. A contrast enhanced computed tomography of abdomen and pelvis and a fluoroscopy scan (Figs 1A to C) revealed the distal loop of the ileostomy was draining into the pouch, which in turn was opening distally into the anal canal. After initial bowel preparation, the patient underwent pouch excision, ileostomy closure with ileorectal anastomosis in January 2014 (Figs 2A to C). Three months later, the girl has been doing well and found continent.

DISCUSSION
The incidence of CPC, among all the cases of ARM, has been reported to occur from 2 to 18%. High incidence
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In case a patient presents with constipation after surgical correction of ARM, it is important to differentiate between rectal ectasia, mega rectum, and CPC. In CPC, there is no anal stenosis. The dilated pouch has typical radiological and histopathological features. It is necessary to consider the possibility of CPC preoperatively in a case of ARM posted for surgery. In one stage, the management of rectovestibular fistula in females, especially in Indian context, the authors suggest the routine use of a simple contrast enema as part of a preoperative workup of these patients in order to diagnose this rare variant subtype of CPC associated with rectovestibular fistula. In this case, the condition was not diagnosed on preoperative abdominal ultrasound and plain X-rays. Failure to do so causes undue vexation to the child, parents, and the treating doctors. Psychosocial problems in patients occur due to multiple surgical procedures, and hospitalization.

(55.8%) of CPC with high ARM has been reported from Udaipur, Rajasthan, India.\(^5\,^6\)

CONCLUSION
It is advisable to investigate and keep possibility of CPC in a female patient of low ARM.

REFERENCES