HARRISON
MEDICAL CENTER
2520 Cherry Ave.
Bremerton, WA 98310

Discharge Date: 10/06/2008
Patient Location: 4W
Patient Type: BIP
Dictating Clinician: G G. FLEISCHHAUER, MD

OPERATIVE NOTE

DATE OF PROCEDURE: 09/18/2008

SURGEON:
G G. FLEISCHHAUER, MD

PREPROCEDURE DIAGNOSIS:
Colourethral fistula

POSTOPERATIVE DIAGNOSIS:
Colourethral fistula.

OPERATION PERFORMED:
1. Exploratory laparotomy.
2. End colostomy.
3. Drainage of space of Retzius.
4. Irrigation of distal rectal stump.
5. Flexible sigmoidoscopy.

SURGEON:
G. G. FLEISCHHAUER MD

ASSISTANT:
SCOTT BILDSTEN DO

ANESTHESIA:
General endotracheal, Dr. Loutzenheiser

REPORT OF PROCEDURE:
This patient was brought to the operating room in stable condition and placed in a supine position on the operating table and a general anesthetic administered by Dr. Loutzenheiser. The abdomen was prepped and draped in the usual manner. He was placed in a lithotomy position. Digital rectal exam revealed no apparent disruption of the rectal repair. This patient 9 days prior to this procedure had undergone a prostatectomy and closure of a rectal laceration. Over the past 9 days the patient has been in the intensive care unit on ventilator support with steady improvement until this morning when he was noted by the nurses to have stool passing around his urinary catheter through his penis. This was a completely new finding. He had no contamination of his urine. The material coming out of his rectum was

OPERATIVE NOTE

similar in consistency and color to that coming out of the urethra and we felt that the most likely cause was a colourethral fistula secondary to a leak or disruption of the rectal repair. This was partially confirmed on preoperative CT scan which showed some free air in the space of Retzius with some fluid in this region. When our digital exam failed to reveal the presence of any rectal disruption we proceeded with an exploratory laparotomy. We opened the old incision and extended it up to the umbilicus. Careful examination of the intraabdominal contents showed no intraperitoneal contamination whatsoever. All the tissues looked good and clean. We decided to proceed with first of all his end colostomy and what we did was divide the sigmoid colon with a GIA 80 stapler and ultimately freed up the mesentery a bit to allow for an end colostomy. This was constructed at the end of the procedure.

At this point in time we decided to do a flexible sigmoidoscopy and get a good look but flexible sigmoidoscopy was hampered by the fact that there was stool throughout the sigmoid colon. After changing gowns and gloves we placed a trocar in the distal portion of the sigmoid colon. This was done by placing a 2-0 silk suture in the colon at the staple line. We then inserted a trocar in the colon and then irrigated with about 5 liters of saline with a tube in the rectum so that we irrigated all the fecal material out of the distal colon. We then closed off the resultant hole in the sigmoid with a TA 60 stapler and repeated the flexible sigmoidoscopy. At this point in time the colon was absolutely clear. We could see the entire distal colon and it all looked fine. The region of the prior repair also looked good. There was no evidence of any disruption of this line but undoubtedly there is a small hole in this suture line. It was just not apparent on visualization. It is our feeling that by diverting the fecal stream we will allow the tissues in the region to heal and we would anticipate that they would heal without the formation of a chronic colovesical fistula. Time will tell on this point. At this point in time we needed to divert the fecal stream and get the patient to clinically improve.

Going back to the abdomen and changing gowns and gloves we created the end colostomy. This was done by excising a circular portion of skin in the left lower quadrant then making a cruciate incision in the fascia and bringing the end of the sigmoid colon out. This was matured with interrupted 3-0 Biosyn sutures at the end of the procedure after the abdomen and skin was closed.

We turned our attention to the region of the space of Retzius and it was clear that there must be contamination in this space. We were somewhat hesitant to open this up for fear of disrupting the fragile urethral anastomosis. However, we gently peeled into the space of Retzius and encountered fecal material. This had undoubtedly leaked out of the rectal closure. This space was now irrigated with copious amounts of saline and a Blake drain placed within it and brought out through a separate stab wound and sutured in place with 2-0 Prolene suture. We now closed the abdominal wall with a running 0 Maxon and the skin with staples.

At the conclusion of the procedure Dr. Bildsten performed a cystoscopy and that report will be separate. The anastomotic line was seen. The cystoscope was passed into the bladder and the bladder was irrigated out and a new Foley catheter was inserted.

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Once again at this point in time we feel that he most certainly has developed a colourethral fistula. Stool leaking out of the rectal laceration was in a tight space of Retzius and was following the path of least resistance through some small hole in the urethral anastomosis. At this point in time all spaces seemed to be clean. The distal rectum was clean and the fecal stream is diverted. Our plan at this point in time will be to get him to clinically improve and some time in the future we will reevaluate the area to see if we can get some closure. We would anticipate that hopefully this will not develop a chronic fistula.

At this point in time the patient had tolerated the procedure quite well. His estimated blood loss was minimal. He is stable and currently in the operating room getting ready to go back to the intensive care unit.

Dictated and Authenticated by
G G. FLEISCHHAUER, MD

GGF/sg
DD: 09/18/2008 22:09 Job No. 101417
DT: 09/19/2008 12:09 Conf. No. 001360

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