

HARVESTING THE HEALTHY GRACILIS FLAP IN RECTOURETHRAL, RECTOVAGINAL, RECTOVESICAL FISTULA: TECHNICAL REFINEMENT

Introduction

Complex perineal fistula repair is difficult interventions and requires surgical experience. In this video we present using gracilis flap in rectourethral, rectovaginal and rectovesical fistula repair. **RESULTS:** Gracilis muscle was easily dissected by hand-assisted technique avoiding extended skin incision. After that, gracilis flap pulled through the small incision just below the perineum near the medial thigh. Neurovascular bundle of the muscle preserved and muscle transposed on the fistula tract. Interposed gracilis flap placed on 3-layer closed fistula tract. **CONCLUSIONS:** Wide dissection of the fistula tract, water-tight 2-3 separate layer closure of the fistula and interposition of the muscle flap are crucial to repair of challenging rectal fistula. Preparation of vital gracilis flap can be harvested without complex devices, paying attention neurovascular supply and anatomical landmarks. Source of Funding: None

Design

METHODS: Between 2009-2015, we repaired rectovaginal, rectourethral and rectovesical fistula by gracilis flap at 2(Nijer, Niamey),3 and 1 patients, respectively. Presented fistula were resulted from extended radical prostatectomy due to high risk locally advanced prostate cancer. **Surgical Technique:** Under general anesthesia, reverse perineal Y incision performed under lithotomy position to reach bulbar urethra. Bulbar urethra with spongiosus muscle released from central tendon. Guidance of the finger in the rectum facilitated blunt and sharp dissection of the fistula tract. External sphincter complex and levator ani muscle were protected by this approach. 12-14 f foley catheter was inserted into the rectum through the fistula, and fibrotic tissues were widely resected by the traction of catheter. Fistula tract was closed by 3-layers with 2/0 absorbable suture, separately. **Preparation of Gracilis flap:** Neurovascular bundle of gracilis was inserted into the proximal 1/3 of the muscle makes it preferable flap to perineum. Four cm vertical incision near to the medial condyl performed and deeply dissected. Sartorius muscle resemble gracilis and dissection must be careful to separate their tendon from each other. Gracilis fascia opened and tendon is hanged. Skin incision was extended towards perineum to mobilize gracilis muscle, or a separate 3 cm skin incision was performed at the mid part of femur.

Results

Gracilis muscle was easily dissected by hand-assisted technique avoiding extended skin incision. After that, gracilis flap pulled through the small incision just below the perineum near the medial thigh. Neurovascular bundle of the muscle preserved and muscle transposed on the fistula tract. Interposed gracilis flap placed on 3-layer closed fistula tract.

Conclusion

Wide dissection of the fistula tract, water-tight 2-3 separate layer closure of the fistula and interposition of the muscle flap are crucial to repair of challenging rectal fistula. Preparation of vital gracilis flap can be harvested without complex devices, paying attention neurovascular supply and anatomical landmarks.

References

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Disclosures

Funding: None **Clinical Trial:** No **Subjects:** HUMAN **Ethics Committee:** Bezmialem Regional Ethics Committee **Helsinki:** Yes **Informed Consent:** Yes