**INTRODUCTION**

Most coitus-related vaginal injuries are minor haemorrhages or fissures that are self-limiting and heal without intervention. Commonly injured areas are posterior, right or left fornix and lower vagina. Severe form of injury extending from posterior vaginal wall to the rectum resulting in fecal fistula is rare. Main causes of rectovaginal fistulae are obstetric or operative trauma, inflammatory bowel disease, malignancy, and radiations. Coitus-related sex injuries seldom occur in a consent sex. A careful history, detailed examination, and sound repair are essential for the fistula to be managed properly. Sex education of the partner is important to prevent recurrence.

**CASE REPORT**

A 22-year female got married to her cousin. Two days after her marriage, during intercourse, she experienced severe pain and bleeding per vagina. Bleeding settled spontaneously after sometime, but the pain persisted. During defecation, she felt feces coming from vagina and later passage of flatus per vagina. There was no history of alcohol usage by both partners and the husband denied usage of sex-enhancing drugs. There was no history of previous perineal surgery, alteration of bowel habits, malignancy or exposure to radiations. She took medications from the local general practitioners for 2 weeks and then reported to our department.

She looked depressed but had stable vital signs. On per vaginal examination, there was a rent of about 3 cm in the posterior vaginal wall communicating with the lower part of rectum and upper anal canal. On per rectal examination, 3 cm tear was seen in the anterior wall of rectum with finger entering the vagina (Figure 1). Local tissues were edematous and infected due to fecal soiling. Upper fibers of the internal sphincter were disrupted; however, anal tone was normal.

After counselling the patient and the husband, staged repair of the fistula was planned, keeping in mind delayed presentation and infected edematous tissues. Repair of fistula was attempted trans-vaginally 2 weeks after left iliac fossa trephine defunctioning sigmoid colostomy. Vaginal mucosal advancement flap was raised. Defects in the rectal wall and upper fibers of internal sphincter were repaired with monofilamentous delayed absorbable 3/0 sutures (Figure 2). Perineal fibers were approximated and vaginal mucosal advancement flap was sutured to the lower end of...
introitus with the delayed absorbable monofilamentous 3/0 sutures. Vaginal pack was placed.

Patient had good healing of the fistula and the colostomy was closed after one month of fistula surgery under antibiotic cover. Patient is continent for her flatus and faeces in 6 months’ follow-up.

DISCUSSION
Coitus related injuries are mostly minor and self limiting and seldom requires operative intervention. Injuries severe enough to cause fistula between vaginal and rectum are very rare. Report from Hospital based studies from Calabar, Nigeria revealed that coital injuries accounted for 0.7 per 1000 gynecological emergencies in which rape was the commonest etiological factor. Different factors contribute to the vaginal injuries during intercourse including lack of sex education, vagino- penile disproportion, virginity, faulty position during intercourse especially dorsal decubitus, influence of drug or alcohol, use of sex-enhancing drugs and rape. In the reported case, lack of sex education and dorsal decubitus position was the probable causative factor as evident from the history. In countries like ours, sex education is lacking, especially in people with low socio-economic and rural background.

History and clinical examination are sufficient to make a diagnosis. However, patient may give false history in a case of non-consensual or extra marital sexual relations. Management is surgical but failure is distressing to the patient and most unsatisfying to the surgeon. Diversion colostomy, prior to the repair and correction of sepsis, aids in the success of repair. Repair can be done transvaginally with or without interposition of healthy tissues like bulbocavernosus or gracilus muscles. Continence is another issue and depends upon the status of sphincter before the repair and the repair itself. Successful repair results in continent patient who is back for her normal daily life and sexual function.

Rectovaginal fistula after consensual sex is extremely rare. Lack of sex education and virginity were the main factors in the reported case.

REFERENCES