<table>
<thead>
<tr>
<th>Title</th>
<th>Colovesical fistula due to sigmoid colon diverticulitis: a case report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>Rahman, Masood; Tokunaga, Shuji; Ikeda, Daisuke; Yokoyama, Osamu; Ohkawa, Mitsuo; Fujita, Hideto; Nishimura, Genichi</td>
</tr>
<tr>
<td>Citation</td>
<td>泌尿器科紀要 (1995), 41(3): 231-234</td>
</tr>
<tr>
<td>Issue Date</td>
<td>1995-03</td>
</tr>
<tr>
<td>URL</td>
<td><a href="http://hdl.handle.net/2433/115459">http://hdl.handle.net/2433/115459</a></td>
</tr>
<tr>
<td>Type</td>
<td>Departmental Bulletin Paper</td>
</tr>
</tbody>
</table>

Kyoto University
Colovesical Fistula due to Sigmoid Colon Diverticulitis: A Case Report

Masood Rahman, Shuji Tokunaga, Daisuke Ikeda, Osamu Yokoyama and Mitsuo Ohkawa

From the Department of Urology, School of Medicine, Kanazawa University

Hideto Fujita and Genichi Nishimura

From the Second Department of Surgery, School of Medicine, Kanazawa University

We present a case of colovesical fistula due to sigmoid colon diverticulitis. A 53-year-old woman was referred to our department with the complaints of dysuria, turbid and foul smelling urine. She was treated twice for acute cystitis at the referral hospitals. A diagnosis of colovesical fistula was confirmed on barium enema. She underwent partial resection of sigmoid colon with primary anastomosis and partial cystectomy with repair of bladder wall and covered with omentum. Retrograde cytography taken on the 20th post-operative day revealed no leakage of contrast medium. She was asymptomatic at 3 months of follow-up.


Key words: Colovesical fistula, Sigmoid colon diverticulitis.

INTRODUCTION

Colovesical fistulas are usually a complication of inflammatory or neoplastic conditions. The most common cause of colovesical fistula is diverticular disease of the colon. Colovesical fistula due to diverticular disease is common in western countries but is an uncommon disease in Japan. We report a case of colovesical fistula due to diverticulitis of the sigmoid colon.

CASE REPORT

A 63-year-old woman was referred to our department on 1st June, 1994 with the chief complaints of dysuria, turbid and foul smelling urine. She was treated twice for acute cystitis at the referral hospitals in April and May of 1994, respectively. Her past history included appendectomy at age 17 and Caesarean section at age 31. Physical examination revealed no abdominal or pelvic mass. Urinalysis revealed pyuria and bacteriuria. Cystoscopy findings included localized inflammation and bullous edema of the bladder mucosa, feces was seen adherent to the posterior bladder wall and no fistula was seen. Excretory urography revealed no appearance of contrast medium in the bowel. A provisional diagnosis of enterovesical fistula was made and she was admitted for extensive examination and treatment.

On admission, sigmoidoscopy revealed multiple diverticulosis of the sigmoid colon. Retrograde cystography revealed extrinsic deformity and irregularity of the bladder wall, no presence of contrast medium in the bowel and no evidence of a fistula (Fig. 1). Barium enema revealed appearance of barium in the bladder, suggesting the presence of a vesicosigmoidal fistula (Fig. 2). Computed tomography (CT) showed thickening of the posterior bladder wall and no fistula. Urine culture revealed Enterococcus species (6 x 10⁶ cfu/ml). A diagnosis of vesicosigmoidal fistula was made. One-stage operation was performed on June 29. On laparotomy, sigmoid colon diverticular mass was adherent to the posterior bladder wall. Partial resection of the sigmoid colon with primary anastomosis and partial cystectomy with closure of the bladder defect were performed.
The bladder defect was closed with vicryl and was covered with omentum. Her postoperative recovery was good. Retrograde cystography taken on the 20th postoperative day demonstrated no appearance of contrast medium in the bowel, and subsequently indwelling urethral catheter was removed. She remained free of symptoms at 3 months of follow-up. Pathological assessment was sigmoid colon diverticulosis with diverticulitis and formation of vesicosigmoidal fistula (Fig. 3).

DISCUSSION

Diverticular disease of the colon affects about 10% and 1% of the population in the westernized countries and Japan respectively. Diagnostic symptoms of colovesical fistula include pneumaturia and fecaluria. Sigmoidoscopy was diagnostic in 10 out of 74 patients (14%) and cystoscopy was diagnostic in 67 out of 87 patients (77%). A diagnosis of fistula was made on cystoscopy in 10 out of 18 patients (56%) and on cystography in 5 out of 12 patients (42%) tested. The presence of a fistula on barium enema was demonstrated in 12 out of 24 patients (50%). In our case, a diagnosis of colovesical fistula due to sigmoid colon diverticulitis was confirmed on barium enema. More recently, CT scan has a diagnostic accuracy in excess of 90% but in this case, only thickening of the posterior bladder wall and no fistula was detected on CT scanning. No single study can confirm all cases of colovesical fistulas, and several studies are necessary to diagnose a colovesical fistula.

Surgical treatment for colovesical fistula is necessary. In the surgical management, the patient's age, general condition and the cause and severity of the primary disease must be considered. A one-stage operative treatment for vesicosigmoidal fistula is an acceptable choice in patients with good nutrition, an optimal bowel preparation, and normal bowel for anastomos-
sis, if the underlying cause is inflammatory. In our case, the patient's general condition was good and the cause of fistula was diverticulitis of the sigmoid colon. Therefore, her post-operative recovery was excellent with one-stage operative treatment and she was discharged free of symptoms 21 days after operation. Furthermore, she was symptomless at 3 months follow-up.

Colovesical fistula has been reported in 1 out of 3,000 surgical admission and 2 to 23 percent of the patients with diverticulitis have a colovesical fistula. Although the most common cause of colovesical fistula is diverticular disease in the westernized countries and as well as in Japan, there are differences in the age group, male/female ratio and site of involvement between these two regions. People in the age group of <60 years old in Japan and >60 years old in the westernized countries are usually affected. Male/female ratio in Japan is 3.3~4:11,12 and in the westernized countries is 3:1. Sigmoid colon is mostly involved in the westernized countries, but the ascending colon is mostly affected in Japan11. In our case, the patient's were over 60 years old and the sigmoid colon was the cause of colovesical fistula, as in the western countries.

Recently, diverticular disease of the colon has been increasing in frequency in Japan, the most common cause of colovesical fistula. Over 110 cases have been reported in Japan11. In the past, the Japanese people used to consume diets high in cereal fiber but recently, the dietary habits are changing to western type of diet, which is low in cereal fiber. There has been reported to be an inverse relationship between the dietary concentration of cereal fiber and the prevalence of colonic diverticulitis. Moreover, the aging of the population in Japan also contributes to the increasing frequency of diverticular disease.

In conclusion, we presented a case of vesicosigmoidal fistula due to sigmoid colon diverticulitis. A one-stage operative treatment was performed with good post-operative recovery.

REFERENCES

5) Shatila AH and Ackerman NB: Diagnosis and management of colovesical fistulas. Surg Gynecol Obstet 143: 71-74, 1976

(Received on October 14, 1994) (Accepted on December 12, 1994)
和文抄録

S状結腸憩室炎に起因したS状結腸膀胱瘻の1例

金沢大学医学部泌尿器科学教室（主任代理：大川光央 助教授）
ラーマン・マスード，徳永 周二，池田 大助
横山 修，大川 光央

金沢大学医学部第二外科学教室（主任：宮崎信夫 教授）
藤田 秀樹，西村 元一

63歳女性にみられたS状結腸憩室炎に起因したS状
結腸膀胱瘻の1例を報告する。痛みを伴う排尿困難と
混濁し便臭のする尿を主訴に、金沢大学医学部附属病
院泌尿器科を紹介された。患者はそれぞれ2回，急性
膀胱炎に対して治療を受けていた。注腸検査でS状結
腸膀胱瘻が明らかとなり，S状結腸部分切除術と縫合
部を大網で被った膀胱部分切除術が施行された。手術
20日後の逆行性膀胱造影では造影剤の漏れはなく，
術後3カ月後の現在，何ら症状を認めていない。S状
結腸憩室炎に起因するS状結腸膀胱瘻は，食生活の欧
米化や高齢化に伴って本邦でも今後，増加するものと
考えられた。

（泌尿紀要 41：231-234，1995）