Posterior Sagittal Anorectoplasty (PSARP) for Males with Recto-urethral Bulbar Fistula and Prostatic Fistula

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- A Foley catheter is inserted.
- The patient is placed prone on the operating table with the pelvis elevated (Fig. 1).
- A posterior sagittal incision is made, staying precisely in the midline, dividing the skin, subcutaneous tissue, parasagittal fibres, muscle complex, and levator mechanism (Figs. 2 and 3).
- A white fascia covering the posterior rectal wall is identified (Fig. 4).
- 5-0 Silk stitches are placed in the posterior rectal wall, that is opened in the midline (Fig. 5).
- More silk stitches are placed in the rectal wall edges as the opening of the rectum continues (Fig. 6).
- The fistula is identified in the midline.
- Multiple 6-0 silk stitches are placed in the hemicircumference above the fistula, and one 6-0 silk stitch is placed in the lower edge of the fistula (Fig. 7).

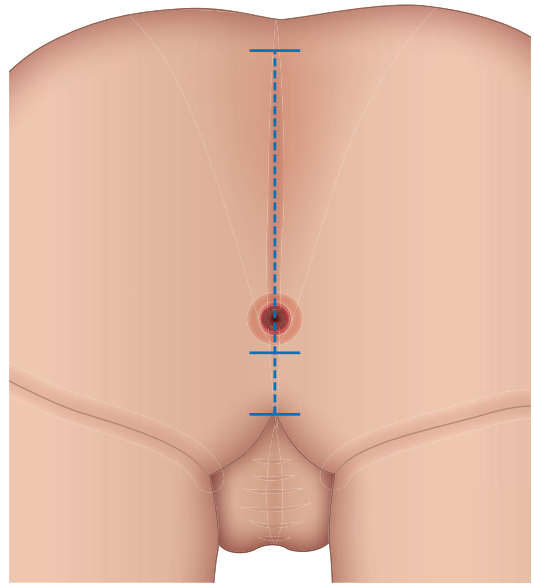

Fig. 1

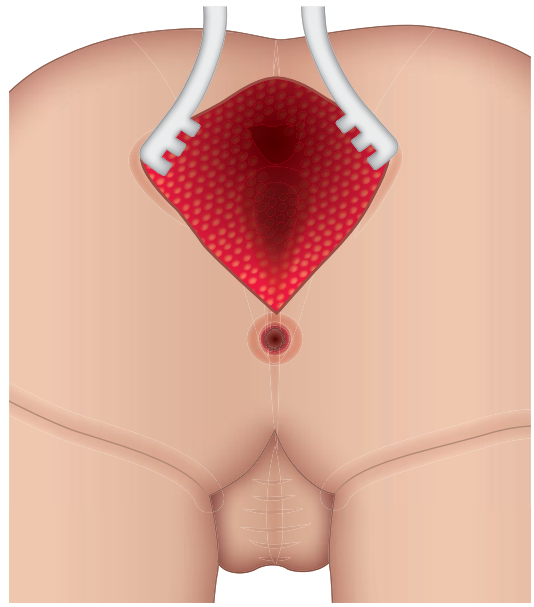

Fig. 2

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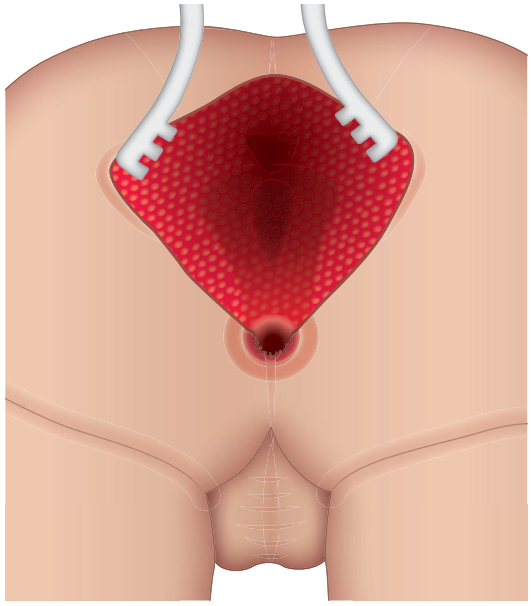

Fig. 3

- A submucosal plane of dissection is created between the anterior rectal wall above the fistula site and the urinary tract for several millimetres, and once the walls are more separated proceeds full thickness, applying uniform traction on the multiple silk sutures previously placed on the edges of the rectal wall and the superior hemicircumference of the fistula (Fig. 8).
- To facilitate separation of the rectum from the urinary tract, it is strongly recommended to proceed cautiously, checking the thickness of the anterior rectal wall frequently and intermittently dissecting the lateral rectal walls.
- Once the rectum is completely separated from the urethra, rectal bands and vessels need to be divided and burned in order to gain enough rectal length to achieve a perineal anastomosis without tension.
- The posterior and anterior limits of the sphincter are determined with the use of an electrical stimulator.

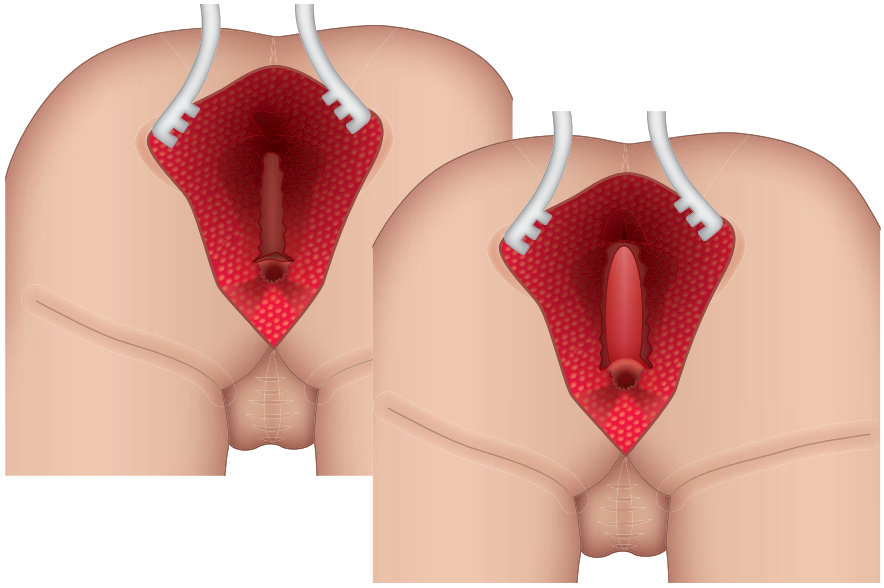

Fig. 4

- The fistula site is identified by the one 6-0 silk stitch previously placed in the lower edge of the fistula and closed with interrupted long-term absorbable suture (Fig. 9).
- The perineal body is then reconstructed bringing together the anterior limits of the sphincter.

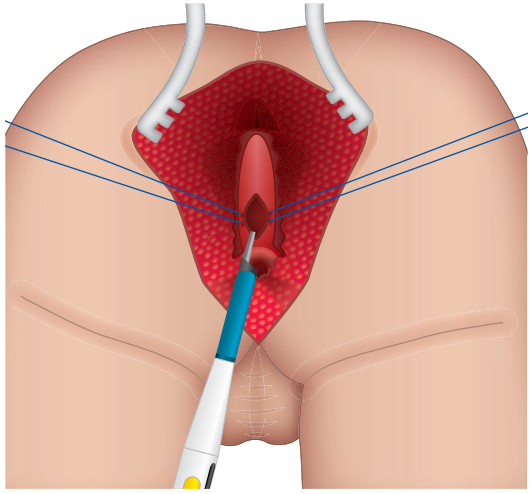

Fig. 5

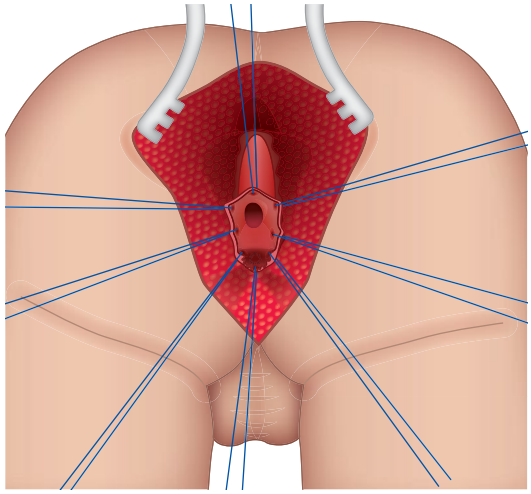

Fig. 6

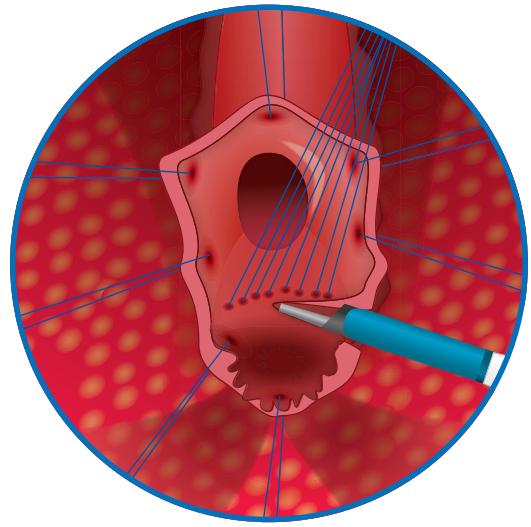

Fig. 7

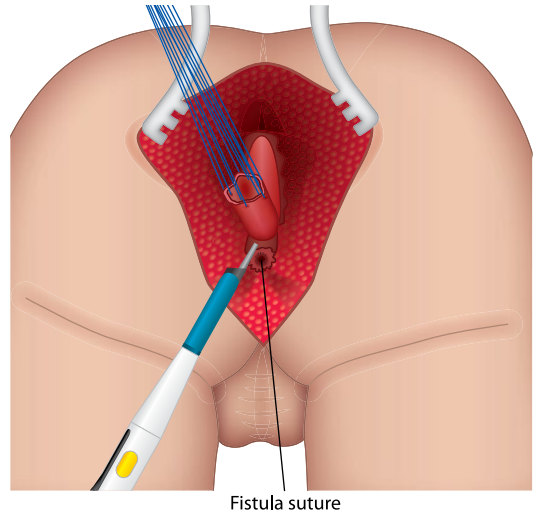

Fig. 8

- The levator muscle must be sutured in the midline, behind the rectum.
- The posterior edges of the muscle complex are sutured together in the midline including, with each stitch, a bite of the posterior rectal wall, to anchor the rectum and avoid tension on the anoplasty and to help avoid prolapse. The ischiorectal space is closed with absorbable sutures.
- The parasagittal fibres are reapproximated.
- The posterior sagittal incision is closed up to the skin.
- An anoplasty is performed with 16 long-term, interrupted absorbable sutures (Fig. 10).

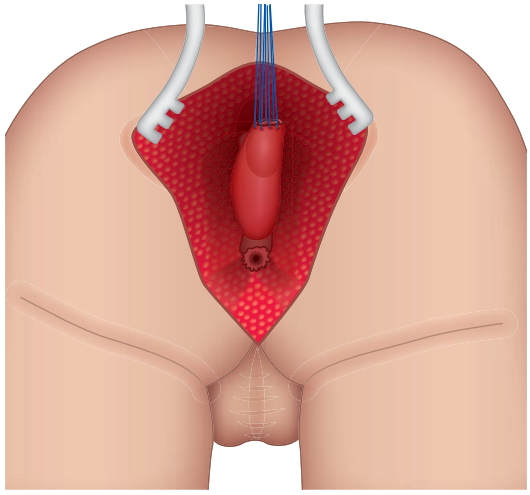

Fig. 9

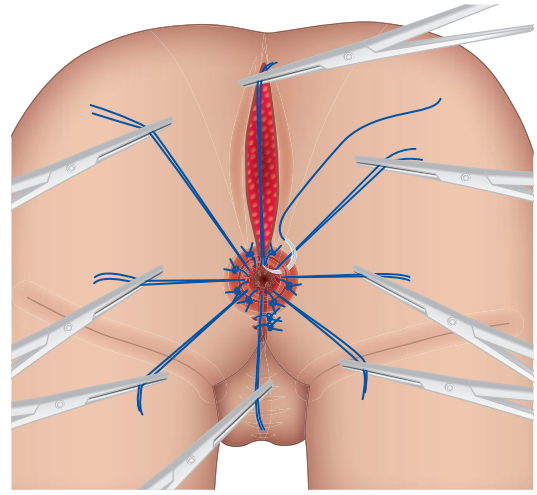

Fig. 10

Tips

- Prior to attempting a posterior sagittal approach, ensure that a high-pressure distal colostogram has been performed to define the anatomy.
- The lower the fistula location is, the longer the common wall between rectum and urethra.
- Rectal dissection must be performed, remaining as close as possible to the rectal wall.
- In cases of prostatic fistulas, the rectum is located immediately below the coccyx, the common wall is short, and the circumferential dissection to gain length is technically demanding.

Common Pitfalls

- Inadvertent urethral injury
- Approaching posterior sagittally a patient without a distal colostogram
- Dissecting the rectum in the wrong plane (too far away from the rectal wall)
- Trying to gain length in a short piece of rectum after a defective, too distally placed colostomy
- Searching for the rectum posterior sagittally in the case of recto–bladder neck fistula