

OBSTETRIC VESICOVAGINAL FISTULA – STILL A REALITY IN DEVELOPING COUNTRIES IN TODAY'S TIME

Hypothesis / aims of study

To review the aetiology and results of management of 50 cases of vesicovaginal fistula (VVF)

Study design, materials and methods

Retrospective clinical study. Records of 50 women, operated for VVF over a period of 12 years, were reviewed. History was analysed to find out the factors associated with the development of fistula. The site, size and type of fistula, surrounding fibrosis, the technique of repair and the no of attempts were recorded. The outcome of repair was evaluated.

Results

The mean age of patients was 28.7 years (range 14-42). Forty-one patients (82%) had an obstetrical cause for fistula; the causes were- prolonged obstructed labor (25), rupture uterus following prolonged neglected obstructed labor (12), forceps delivery (2) and caesarean section (2). Of the 12 cases of rupture uterus, 3 had undergone hysterectomy. The causes of gynecological fistulae were Wertheim's hysterectomy (1), abdominal hysterectomy (4), postcoital (2) and vaginoplasty (2).

Fortyfive patients had single fistule, three had 2 and two patients had 3 fistulae. The mean diameter of the fistula was 2.5 cm (range 0.8-5.0). The types of fistula, as per Lawson's classification were juxta- urethral -13 (bladder neck- 10 and urethrovesicocervical -3), vault -13, mid vaginal -15 and juxtacervical -9.[1] All repair operations were performed by vaginal route with the patient in lithotomy position. Trendelenburg angulation was added for fistulae involving the vault. Repair operations were performed mainly by vaginal flap technique. The fistulous track was excised.[2] Latzko operation was done for post hysterectomy vault fistulae. [3] Martius graft was used in 5 cases.

Successful closure was achieved in 36 repairs 72%. Postoperative stress incontinence was observed in 3 cases. Failed repairs were observed only in patients having fistulae following obstructed labor (10/24) and its complications ie rupture uterus (4/12). Of 45 single fistulae, 32 (71.11%) attained successful closure. Success rate for 2- and 3- fistulae was 100% and 50% respectively. Success rate for small (up to 1 cm), medium (1-3cm) and large fistulae (> 3 cm) was 85%, 72.2% and 45.45 % respectively. The failure rate was directly related to the degree of fibrosis. Whereas 100% success was achieved in fistulae with no fibrosis, it came down to 16.66% in fistulae with excessive fibrosis. The mean postoperative hospital stay was 26 days (range 14-65 days)

Interpretation of results

Neglected obstructed labor was the major cause of VVF. Where as all fistulae of gynaecologic origin were closed successfully, only 27/41 (65.85%) of obstetric fistula repairs were successful. Factors favourable for success were - a non-obstetric etiology, small sized fistula (< 10 mm) and absence of fibrosis.

Concluding message

Neglected obstructed labor still exists in developing nations and is responsible for producing these deadly VVF. Prevention, by means of improving the antenatal and intranatal health services, should be our goal. However the affected women must get the timely treatment.

Key word :- Fistula

References

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<i>Was the Declaration of Helsinki followed?</i>	No
<i>This study did not follow the Declaration of Helsinki in the sense that</i>	it was a retrospective study.
<i>Was informed consent obtained from the patients?</i>	No