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THE SURGICAL MANAGEMENT OF OBSTETRIC FISTULA: A PERSONAL SERIES OF 299 CASES.

Hypothesis / aims of study

The aims of the study were twofold: (1) to analyse the social impact and of obstetric fistula; and (2) to analyse the results of fistula repair by a single surgeon in the developing world.

Study design, materials and methods

Eleven years of fistula surgery by a single surgeon in Gambia, Sierra Leon and Egypt were analysed from April 1996 to Oct. 2010.

with Basic principles of fistula repair were applied:

- Adequate access, good light, suitable position of the patient: Labial retraction sutures help to improve access, including episiotomy, sometimes bilateral in case of extensive scar tissue and vaginal narrowing.
- Mobilization of the fistula: The fistula is circumscribed using a small blade (number 12, the vaginal skin is then dissected off the bladder, excision of the fistula edge and fibrous tissue to do tension free repair in two layers.
- Repair without tension: Continuous or interrupted inverted mattress sutures are applied using 2/0 or 3/0 polyglycolic acid. or any delayed absorbable sutures

-Closing the fistula angles the corner stone of the success of the operation.

Sometime we need to fix the fistula to the inner aspect of the pubic bone especially in the circumferential type to make tension free repair.

-The omental flap used for trans-abdominal repair while martius flap was indicated for all transvaginal VVF repair when size more than one cm.

Results

Total number of patients 299 cases.

Age of patients at the time of complaint:

- < 20 years: 144 patients (48.2%)
- 21-30 years: 98 patients (32.7%)
- > 30 years: 57 patients (19.1%)

271 patients (91%%)were complaining of urinary incontinence(mainly fistula),22 (7.3%)patients were complaining of both urinary and stool incontinence , while 5 patients (1.7)%were complaining of stool incontinence . while one patient was suffering of Uterocutaneous Fistula. From this work we can observe the social aspect of the problem, the partners of 210 patients (70.3%) has left them after the occurrence of the problem, while 89 (29.7%) partner stayed with them.

Those sufferers find themselves most of the time without social support.,137 patients (45.8%) were receiving social support from their parents, 97 patients (32.4%) still receiving their support from their husbands, while 65 patients (21.7%)has almost depends on their relatives, friends, or themselves.

281 patients (94%) caused by obstructed labour, while 18 patients: (6%) were because of surgery (Iatrogenic)

Total numbers of operations : 323 distributed as follows: VVF repair:237 patients (73.4%), Urine diversion(Mainz pouch II): 32patients (9.9%), Ureteroneo-cystostomy (either Trans abdominal or transvaginal), 12 patients (3.4%), Rectovaginal fistula repair: 19 patients (6%), One case Boary flap, 7 Complete perineal tear repair, 7 cases of Vesicouterine fistula repair, 4 Killey's, sutures, 2 cases of burch operation, 1 case of vesico-cutaneous fistula repair, 1 case of utero-cutaneous fistula

Total of succeeded operative procedure: 299 (92.6% success closure rate) while the failed cases are 24 (7.4%)

Interpretation of results

Several papers from Africa have been reviewed, that from Ghana that looked at 150 fistulas came to conclusion that 91.5% were result of obstructed labour and 8.5%were from difficult gyn. Surgery.(1). Tahzib in north Nigeria reviewed 1443 patients with VVF between1969-1980. Home delivery was performed in 64.4% of these women,54.8% were under 20 yrs and only 22.7% were older than 25 yrs, 52% were primigravidas, and 21.5% of fistulas had parity of 4 or more(2).RVF is significantly less than VVF, in a series of patients presenting with VVF, between 6% and 24% had combined VVF and RVF(3)

In experienced and skilled hands, more than 80% closure rates or better are achieved and the

Best chance for successful closure is the first attempt, each technique is unique and the ability to improvise when unexpected findings or complications arise. Is what distinguishes a skilled and experienced fistula surgeon from others?

Interpretation of results

VVF and RVF are common in sub-Saharan Africa, And Asia, especially India, Pakistan, Bangladesh and East Timor, The fistula problems has been neglected by governments, NGO'S, WHO, safe motherhood for long time.

Because the obstetric fistula is related to the maternal mortality, the best way to reduce or to prevent fistula formation is to provide essential obstetric services at the primary health level, also to improve the referral system

Concluding message

VVF and RVF are common in sub-Saharan Africa, And Asia, especially India, Pakistan, Bangladesh and East Timor, The fistula problems has been neglected by governments, NGO'S, WHO, safe motherhood for long time.

Because the obstetric fistula is related to the maternal mortality, the best way to reduce or to prevent fistula formation is to provide essential obstetric services at the primary health level, also to improve the referral system

References

(1): Carter B, Plumbo L, Creadisck RN, Ross RA.1952
(2): Ampofo, Out, and Uchebo 1990, Onolemhen and Ekwempu 1999).
(3): Arrowsmith 1994,Aziz 1965, Bird 1967 and Tahzib 1983 among others).

References

1. (1): Carter B, Plumbo L, Creadisck RN, Ross RA.1952
2. (2): Arrowsmith 1994,Aziz 1965, Bird 1967 and Tahzib 1983 among others).
3. (3): Ampofo, Out, and Uchebo 1990, Onolemhen and Ekwempu 1999).

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Is this a clinical trial?	**No**
What were the subjects in the study?	**HUMAN**
Was this study approved by an ethics committee?	**No**
This study did not require ethics committee approval because	**It was results record of the operation done during my work in Gambia, Sierra Leone, Timor Leste, Egypt**
Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**Yes**