

OPERATION TITLE: INTRAVESICAL FLAP INTERPOSITION FOR VESICO-VAGINAL FISTULA REPAIR

Introduction

The most common type of fistula that results in urinary incontinence is a vesicovaginal fistula usually secondary to gynecologic surgery, radiation, or obstetric trauma. In women fistula may occur between the urethra and vagina, bladder and vagina, and they may involve sometimes even the rectum.

In this film we describe a new vesico-vaginal fistula repair technique with intravesical flap interposition

Design

12 women underwent the following procedure since 2000 under general anesthesia. We recommend a 3 – 6 month interval between the injury and repair. The case in this video is a 50 years old female patient with vesicovaginal fistula close to the bladder neck in the trigone. Fistula repair is secondary to mesh implants for pelvic organ prolapse. In this case, the underlying reason of vaginal fistula is the mesh used for prolapse. The vaginal mesh is excised with a scissor and afterwards the ureteral catheter placed from the vagina is used to determine the exact site of the fistula. The fistula is very close to the bladder neck and within the trigone. The fistula epithelia (including the bladder and vagina) tissue is cauterized without excision. The cauterization is extended around the fistula site and sutured as one or two layers using 2-0 vicril. The bladder epithelia around the sutured fistula are widely cauterized. Under the fistula a rectangular wide bladder tissue including detrusor is cauterized to form a vesical flap. The vesical flap is interpositioned towards the bladder neck to cover the sutured fistula. The interpositioned flap is sutured with the other tissue of the bladder at all four sides without cutting the detrusor completely. Urethral catheters removed suprapubically and completely removed at the 4th or 5th day of the postoperative period. Ureteral catheter is removed about the 15th day of the postoperative period.

Results

Operation time may vary according to fistula size and site. Postoperative follow up was conducted between 6 and 11 months. Urethral catheter was removed within 12-15 days after the intervention. There was no leakage in our cases and the patients were following the procedure completely dry and substantially continent.

Conclusion

In this procedure, appropriate for simple and complex fistulas, intravesical flap (including detrusor) is interpositioned so as to cover the fistula. Simplicity of the procedure, avoidance of extensive bladder dissection, easy interventions for supratrigonal fistula and extraperitoneal nature of the operation, along with a high success rate are the advantages of this procedure.

Disclosures

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