

MANAGEMENT OF OBSTETRIC FISTULAE IN SUB-SAHARAN AFRICA

Hypothesis / aims of study

Obstetric fistulae occur due to the pressure necrosis caused by prolonged labor and insufficient obstetric care. Familial and social isolation are major consequences. The management of obstetric fistulae is complicated and depends on available medical facilities as well as sociocultural perceptions in the individual setting. In this video, we describe transvaginal repair of large vesicovaginal fistulae and report our experience with the management of obstetric fistulae in Sub-Saharan Africa.

Study design, materials and methods

Our group participated in the management of 46 women treated in a fistula clinic in Niger between 2012 and 2013. 18 were primary cases, 28 were treated for recurrent fistula or persistent incontinence after closure. Vesicovaginal (VVF), urethrovaginal (UVF), rectovaginal (RVF), and ureterovaginal (URVF) fistula was present in 19, 10, 2, and 3 women, respectively. One patient had concomitant UVF+RVF. All cases were operated under spinal anesthesia due to poor general anesthesia facilities. After circumferential incision of the fistula tract, the plane between vaginal mucosa and bladder/rectum wall was dissected. In the case of trigonal involvement, circumferential incision was carried out 0.5-1 cm more exterior to the fistula tract after catheterization of ureteral orifices under direct vision from the vagina. After generous mobilization, bladder/rectum wall was closed with running 2/0 vicryl sutures. Vaginal wall was closed primarily following check for leakage with intravesical methylene blue instillation. Urethral catheter was kept for 2-3 weeks.

Results

Mean patient age was 27.5 (16-47) years. A total of 53 procedures were performed on 46 women. Fistula diameter ranged from 1 to 7 cm. in VVF and the trigone was involved in 5 of them. Two women with large VVF associated with total bladder neck and urethral loss could not be repaired. Bladder neck and mid/distal urethra was involved in 7 and 4 patients with UVF, respectively. In 5 of these women, bladder neck/urethral continuity was interrupted (circumferential fistula). Ureteroneocystostomy with a psoas hitch was required in 3 patients with URVF. Six women received vaginal flap urethroplasty due to short urethra after successful fistula closure and persistent stress urinary incontinence. Seven received a mid-urethral sling and four received sacrocolpopexy due to postoperative advanced pelvic organ prolapse. The closure was successful in 83% of primary cases and in 61% women operated for recurrent fistula.

Interpretation of results

Under poor general anesthesia conditions, obstetric fistulae are most amenable to be repaired with the transvaginal approach. Primary closure yields better results in primary cases than in recurrent cases.

Concluding message

The management of obstetric fistulae is demanding. Transvaginal approach provides successful closure in most cases. However, the surgeon should be prepared to perform additional procedures for persistent/recurrent incontinence even after a successful initial closure.

Disclosures

Funding: none **Clinical Trial:** No **Subjects:** HUMAN **Ethics not Req'd:** Local ethics committee not existent. Study approved by clinical director and hospital management instead. Patient consent was obtained. **Helsinki:** Yes **Informed Consent:** Yes