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Paparella P[1], Falconi G[1], Ercoli A [1], Marturano M[1], Paparella R[1], Contreras Ortiz O[2]
1. Catholic University of Sacred Heart of Rome, 2. University of Buenos Aires, Argentina

A PRACTICAL CLASSIFICATION FOR THERAPEUTIC MANAGEMENT OF UROGENITAL FISTULAS .

Aims of Study

The route of surgical approach and timing of surgery are the main arguments of discussion on urogenital fistulas repairing. After reviewing the ways of treatment of urogenital fistulas in "…."evolved during a period of seventythree years ,we suggest a classification to choose the best therapeutical option to cure urogenital fistulas .

Methods

We examined the cases of urogenital fistulas observed in "…" from 1928 to 2001 with particular attention to therapeutic management. Patients were grouped according to the "…" classification [(1) (2)] as having complex or simple fistulas.

Criteria to classify a urogenital fistula as complex [(1) (2)]
1. Important loss of tissue (>5 cm)
2. Mixed*
3. Neoplastic
4. Multiple urogenital localizations **
5. Post-radiotherapy
6. Adherence to bone plane
7. Recidivated

* When others structures are interested (Es.: bowel, blood vessel)
** Two or more structures or organs of urinary and/or genital tract are simultaneously interested (i.e.: urethro-vesico-vaginal, uretero-vesico-vaginal, etc...)

Results

Between 1928 and 2001, 253 patients underwent surgery for urogenital fistulas.; 56 patients had complicated fistulas and 197 had simple urogenital fistulas.
Simple urogenital fistulas and those presenting the two last criteria (24 pts) were successfully treated transvaginally by Fueth's technique. Post-radiotherapy fistulas (15 pts) were cured as well by transvaginal techniques (Fueth's or Latzko's).In the presence of multiple urogenital fistulas (4 pts) or of fistula involving multiple localization of urinary tract (urethra,bladder,ureter) (5 pts) the main criterion in choosing the route of surgery was the relationships with ureter.If it was involved (4 pts), infact,a transabdominal (2 pts) or combined access(2 pts) were preferred to the exclusive vaginal route.Of 8 patients presenting the first three criteria 5 were treated transabdominally and 3 by combined route.
For what concerns the timing of surgery, we repaired simple urogenital fistulas in non-healing cases as soon as possible, in medically stable patients without contraindications to surgery(1-2). For postradiotherapy fistulas repair, we waited about one year, because the typical endoarteritis has a long developing time.

Conclusions

On the basis of the experience of our school we suggest that: the first three criteria of classification are absolute and address to consider a transabdominal or combined approach; the fourth and fifth criterion are semiabsolute because one can consider a transvaginal approach respectively if there is not the ureter involvement and if the local status of bladder wall and perivaginal tissues permit to suture them; the last criteria are relative because surgical choice is dictated only by the presence or absence of the precedent criteria.Transvaginally surgical techniques are less time consuming, have smaller morbidity and shorter post-surgery hospitalization and in consequence gain more acceptability by the patients.