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INCREASING VAGINAL REPAIR OF VESICOVAGINAL FISTULAE DOES NOT AFFECT OUTCOME

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Introduction

- Traditionally In the United Kingdom, Urologists have repaired vesico-vaginal fistulae (VVF) using an abdominal approach whereas Gynaecologists prefer a vaginal approach.
- We have reviewed the routes of repair in a 2 surgeon series of VVF managed at a tertiary Urology referral centre between 2000 and 2017 to determine the changes in practise over this period and success of techniques utilised.

Materials and Methods

- Retrospective analysis was performed on a prospectively acquired database of patients with VVF over a 17 year period (2000-2017).
- Data reviewed included: patient demographics, fistula aetiology, route of repair and final outcome.
- Data was grouped into 5-year data sets (2000-2005; 2006-2010; 2011-2015) and one final 2-year set (2016-2017).
- 139 patients were identified with a median age of 50 years (range 21-88y).
- Abdominal approaches were varied according to co-existing pathology/anatomical abnormalities.
- Vaginal approaches varied according to the anatomy of the fistula but all utilised modified martius fat pad interposition at closure.

Results I

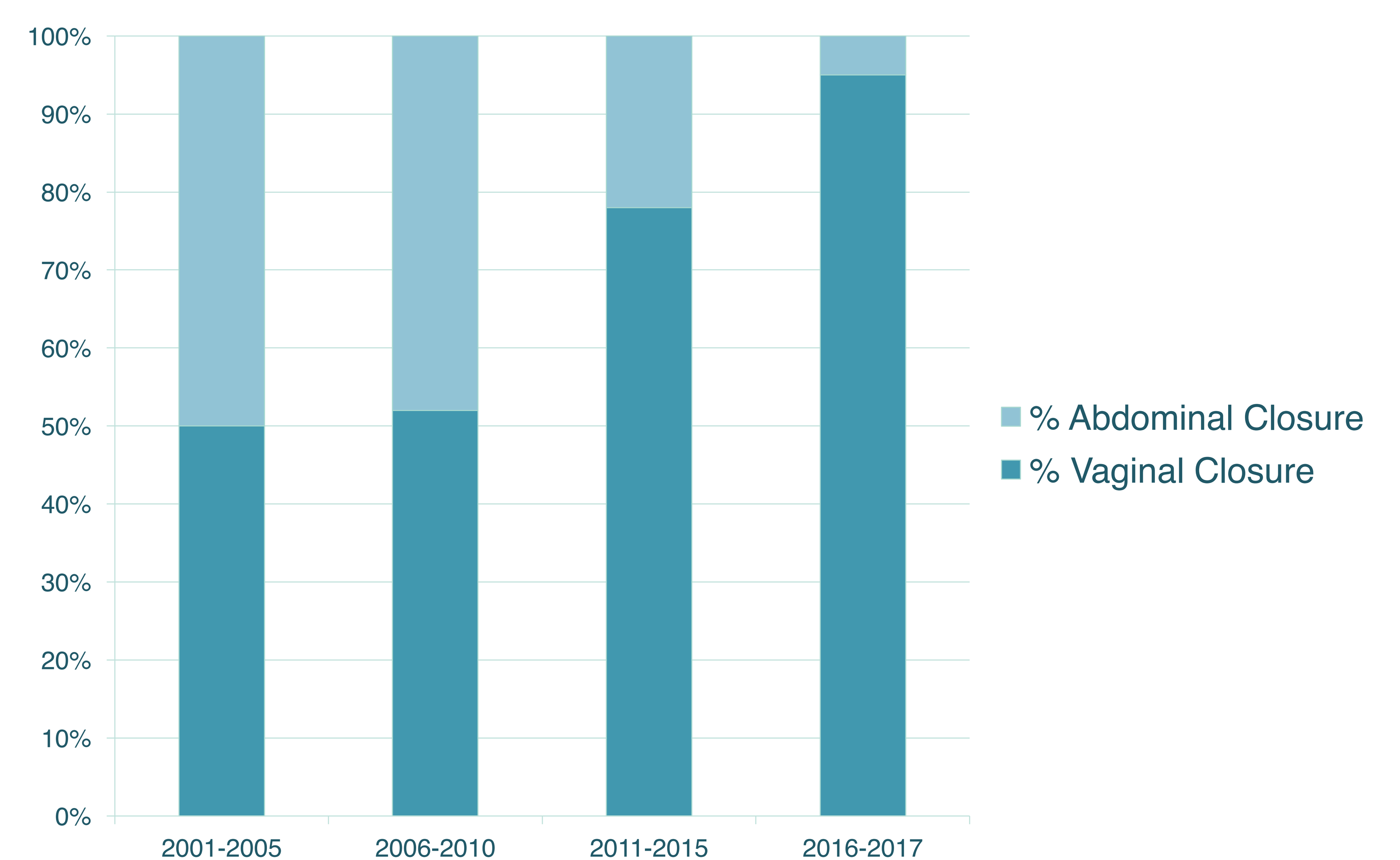
Over the 17 years studied 139 women underwent a total of 155 VVF repairs – 62 via an abdominal route (AR) and 93 using a vaginal route (VR).

Absolute indication for abdominal repair include: ureteric re-implantation and/or clam cystoplasty, or early repair following an abdominal procedure.

Absolute indications for an abdominal repair were present in 9 patients – the remaining 53 women had abdominal repair due to surgeon preference and/or perceived difficulty with vaginal access to the fistula.

Figure 1 outlines the route of VVF repair and how this has changed over the time period analysed.

Figure 1: VVF repair surgical routes over time



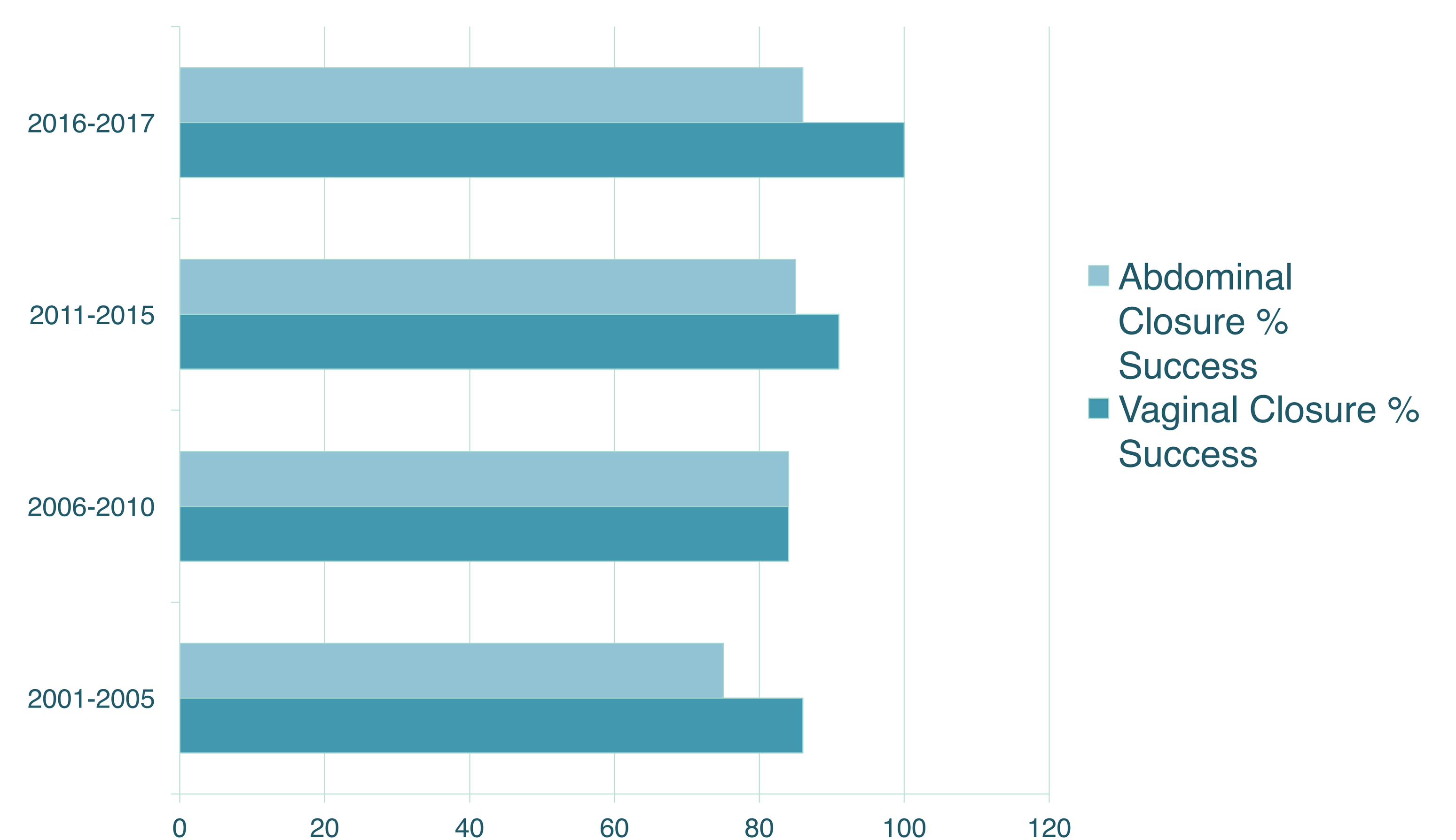
Results II

During the time period studied successful repair of VVF increased from 75% AR and 86% VR at baseline to 86% AR and 100% VR by the end of the analysis period (see Figure 2).

Overall anatomical closure was achieved in 97% with no significant difference between abdominal or vaginal closure routes (P>0.05).

Figure 2 outlines the successful repair rates over the time period analysed

Figure 2: Successful repair rates for VVF



Conclusion

- Vaginal repair is becoming increasingly common in Urology practice with excellent fistula repair outcomes.
- Unless there are absolute indications for abdominal repair a vaginal approach should be the route of choice.