W10: Female Urogenital Fistula; From Simple to the Complex Scenario

Workshop Chair: Sherif Mourad, Egypt
17 September 2025 14:30 - 16:00

Start	End	Topic	Speakers
14:30	14:35	Introduction	Sherif Mourad
14:35	14:40	Etiology and pathology of FUGF	CUNEYD OZKURKCUGIL
14:40	14:50	CLASSIFICATION OF FUGF: BENIGN/ MALIGNANT; SIMPLE/COMPLEX; URETERAL/BLADDER; VAGINAL/UTERINE; URO-GENITO-COLONIC; ETC.	Riyad Al Mousa
14:50	15:00	THE COMMON FISTULAS: VESICO-VAGINAL; URETERO-VAGINAL	Sherif Mourad
15:00	15:10	THE LESS COMMON FISTULAS: VESICO-UTERINE F; URETERO-UTERINE Fistula	CUNEYD OZKURKCUGIL
15:10	15:20	REPAIR OF COMPLEX VESICO-VAGINO-RECTAL FISTULA WITH VIDEO DEMONSTRATION	Sandip Vasavada
15:20	15:30	APPROACHES FOR THE REPAIR OF FUGF	Sherif Mourad
15:30	15:40	SPECIAL TYPE OF FISTULAS: POST-DIVERION POUCH-VAGINAL F; POST-RADIATION F; MALIGNANT FUGF	Riyad Al Mousa
15:40	15:50	ROBOTIC SINGLE PORT VESICOVAGINAL FISTULA REPAIR	Sandip Vasavada
15:50	16:00	Questions	All

Description

By the end of this workshop the participants will be able to: - Enlist the various etiological causes of female urogenital fistula (FUGF) in developed and developing countries and also in well developed countries. - Describe the diagnostic steps of FUGF including the different classification systems. - Draw a plan for treatment of simple and complex FUGF probably related to the given data from classification, diagnostic information and surgical capabilities and the available surgical tools and facilities. - Discuss the surgical tips and tricks in the repair of FUGF including the possible complications that may occur during or after the surgeries. - Compose an algorithm for the role of laparoscopy and robot-assisted techniques in the repair of these fistulas. - Analyze the post-operative outcome, including the continence and voiding status. - Get insight into the risk factors and causes of treatment failure. As General Recommendations: - The comprehensive use of an indwelling catheter with free urinary drainage should be instituted for all patients who have undergone either an emergency caesarean section or a traumatic vaginal delivery after prolonged (>24hours) obstructed labour. - Spontaneous closure of surgical fistulae does occur, although it is not possible to establish the rate with any certainty; if a vesicovaginal fistula is diagnosed within six weeks of surgery, indwelling catheterisation can be considered for a period of up to 9 weeks (i.e. up to 12 weeks after the causative event) - Attention should be given as appropriate to skin care, nutrition, rehabilitation, counselling and support prior to and following fistula repair - There is no benefit from mechanical or laxative bowel preparation prior to colonic surgery; it is reasonable that this recommendation be extrapolated to apply to fistula surgery - There is no proven benefit to delayed repair of vesicovaginal fistula; the timing of repair should be tailored to the individual patient and surgeon requirements, but can be undertaken as soon as any oedema, inflammation, tissue necrosis, infection are resolved - There are no high quality data to indicate greater cure rates for any one technique as compared to others ; level 3 evidence indicates similar success rates for vaginal and abdominal, and for transvesical and transperitoneal approaches - Surgeons involved in fistula surgery should have appropriate training, skills, and experience to select an appropriate procedure for each patient - The majority of vesico-vaginal and all urethro-vaginal fistulae can be repaired vaginally, regardless of aetiology - Where concurrent ureteric re-implantation or augmentation cystoplasty are required, the abdominal approach is necessary. - A variety of interpositional grafts can be used in either abdominal or vaginal procedures, although there is little evidence to support their use in any specific setting - Conventional and robotically-assisted laparoscopic approaches have both been shown to be feasible in selected cases; the indications for, or optimal patient for these techniques has to be considered carefully. - A period of continuous bladder drainage is crucial to successful fistula repair; there are no high level data to support any particular type, route, or duration of catheterization; current practice suggests: 10-14 days for simple and/or post-surgical fistulae; 14-21 days for complex and/or post-radiation fistulae.

Aims of Workshop

By the end of this workshop the participants will be able to: Enlist the various etiological causes of female urogenital fistula (FUGF) in developed and developing countries. Describe the diagnostic steps of FUGF. Draw a plan for treatment of simple and complex FUGF. Discuss the surgical tips and tricks in the repair of FUGF. Compose an algorithm for the role of laparoscopy and robot-assisted techniques in the repair of these fistulas. Analyze the post-operative outcome, including the continence and voiding status. Get insight into the risk factors and causes of treatment failure.

Educational Objectives

The workshop will include all the required data of the problem starting from the possible etiology and pathoetiological factors to the different techniques of repair and how to overcome the difficulties and complications of these cases.

The tips and tricks learned here can be easily applied by those who are already involved in these kinds of surgical repair and reconstructive surgeries. For those who are starting and interested, they can join our hands-on training courses and workshops of surgical repair of genital fistulas.

Learning Objectives

1. Classification and Diagnosis of FUGF
2. Algorithm of treatment options
3. Dealing with the operative and postoperative complications

Target Audience

Urology, Urogynaecology and Female & Functional Urology

Advanced/Basic

Intermediate

Suggested Learning before Workshop Attendance

Obstetric Vesicovaginal Fistula
Urinary Fistula