

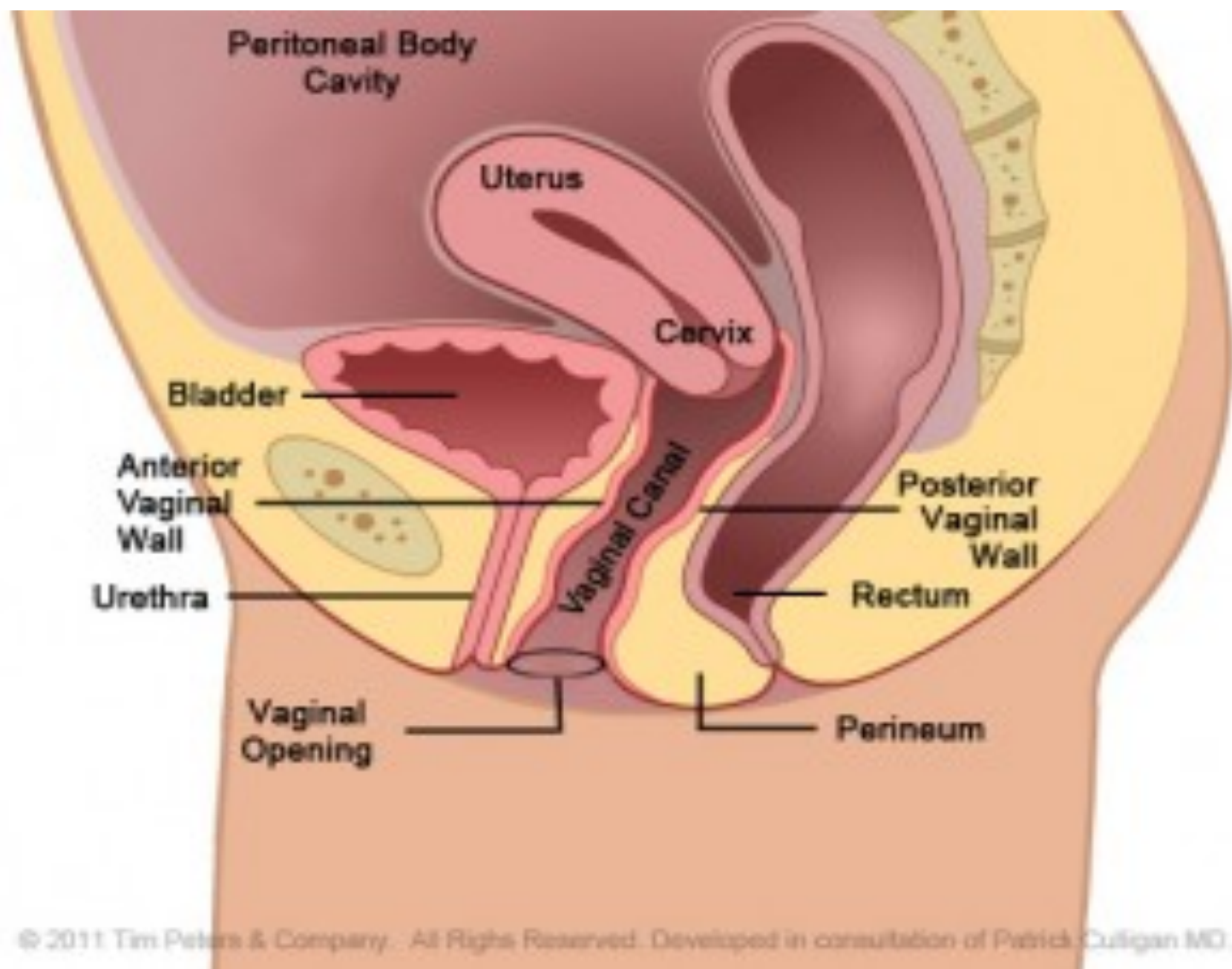
Vesico Vaginal Fistula/Recto- Vaginal Fistula

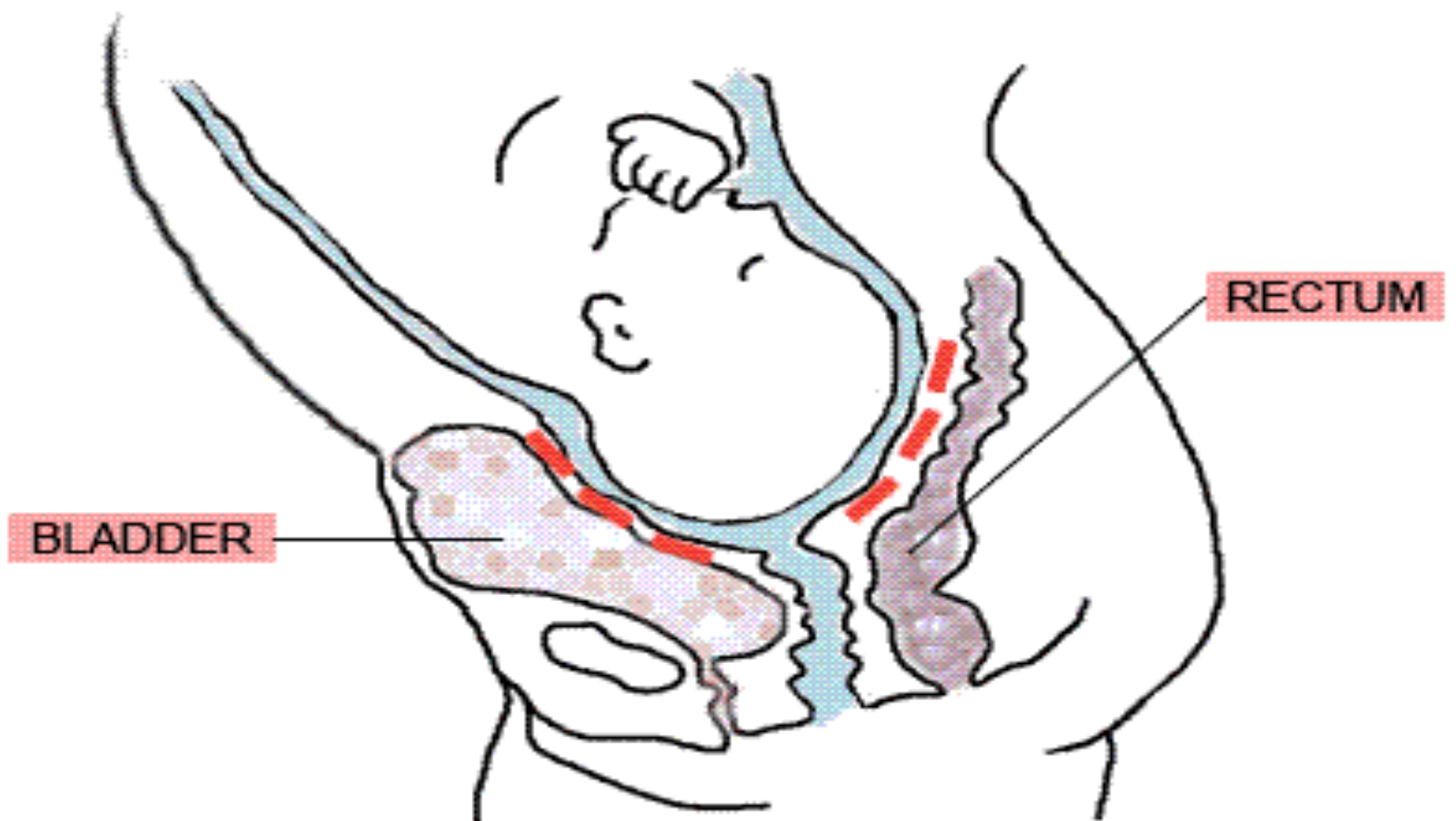
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2017

What is a fistula in the context of rep tract and urinary/GIT?

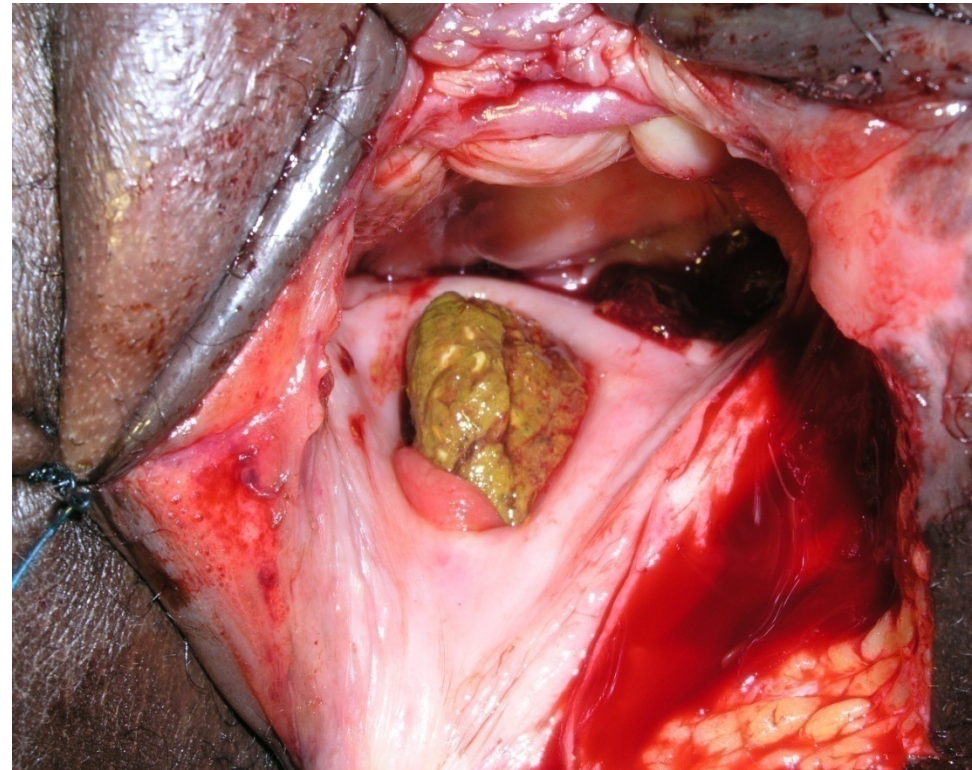
- In this case communication between the urinary tract or lower Gastro-intestinal tract and the reproductive tract
- Patients will present with incontinence of urine and or stool -continuous passage of these body fluids
- Need to rule out other causes of incontinence

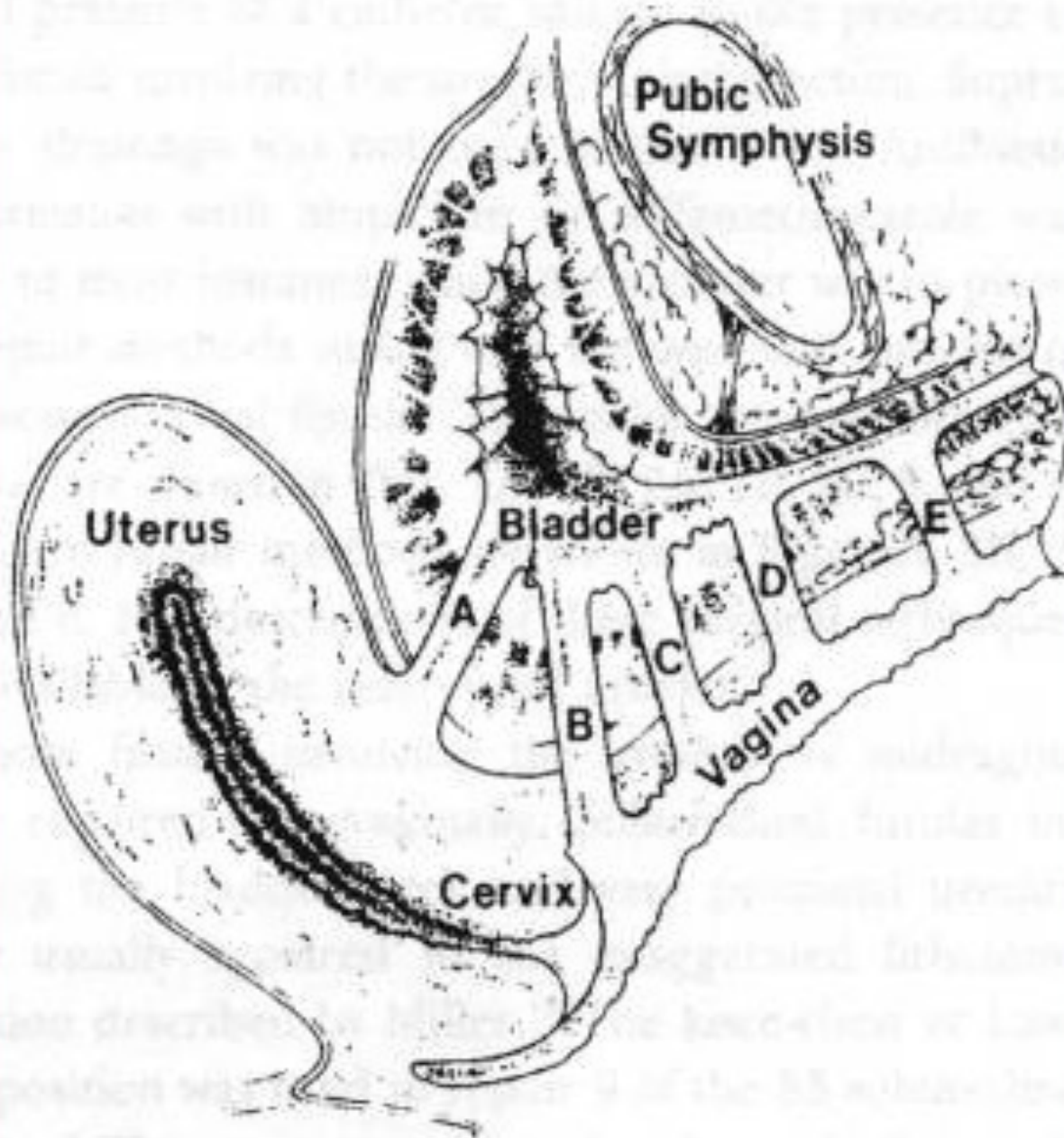




During prolonged labour, the compression of soft tissues (as indicated by the red lines) between the baby's head and the woman's pelvis cuts off blood flow to the bladder or rectum. As a result, tissue dies, leaving a hole, or fistula.

Vesico- and rectovaginal fistula





Vesico-vaginal

Vesico-uterine

Vesico-cervical-vaginal

Uretero-vaginal

Recto-vaginal

Objectives-by the end of the session the student will know the following:-

- Definition/classification
- Clinical assessment
 - History
 - Examination
- Investigations

Objectives

- Treatment
 - Counselling
 - Anaesthesia
 - Surgical approach
 - Pre and post operative management
- Complications
- Addressing other medical issues
- PREVENTION

Classificaiton of VVF

Figure 58 Closing mechanism

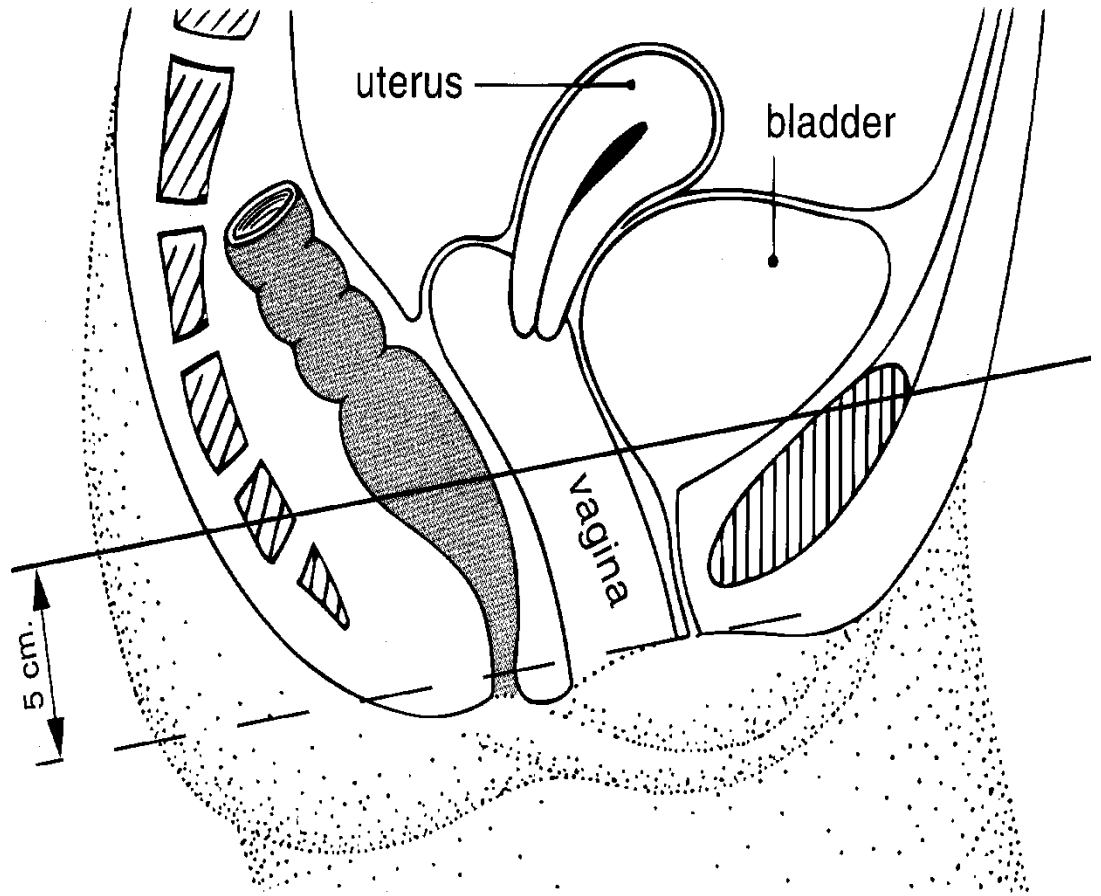
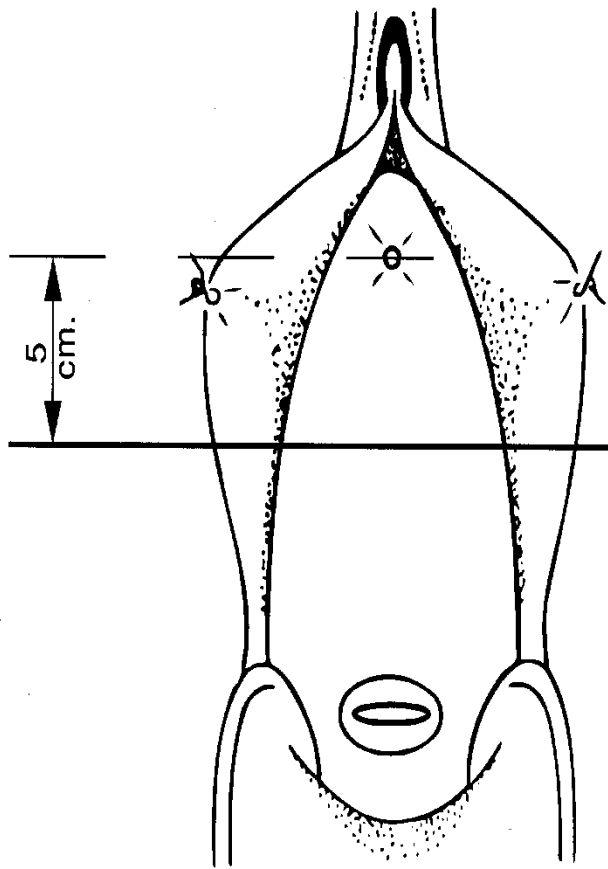


Figure 58-b Closing mechanism: sagittal

Figure 58-a Closing mechanism: frontal

Anatomic Classification-also known as Kees Walddiyk classification

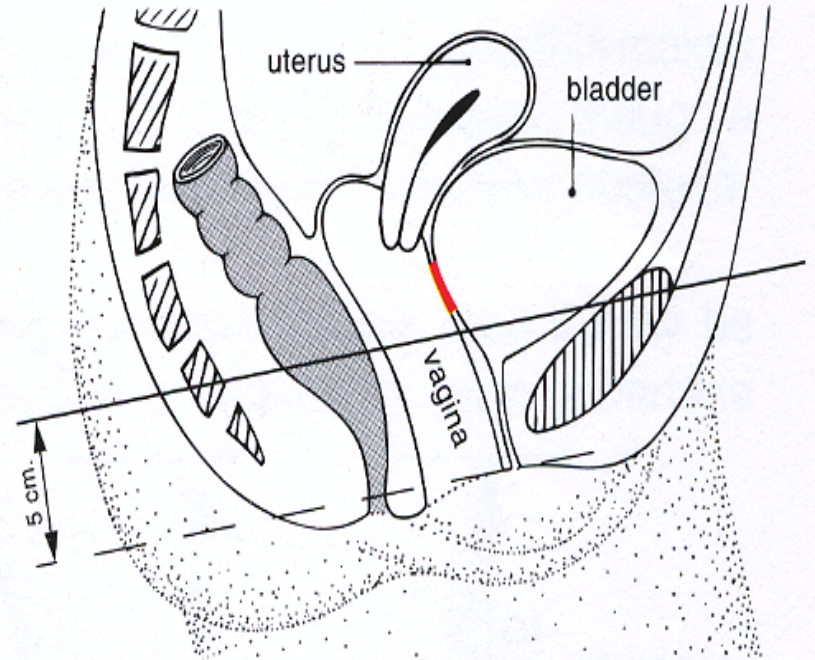
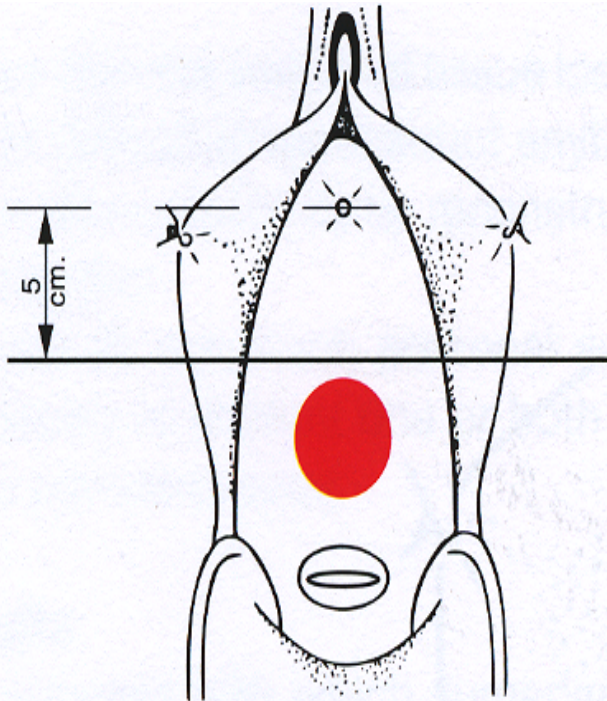
- Type I: Not involving the closing mechanism
- Type II: Involving the closing Mechanism
 - A : Not involving (sub) total urethra
 - a : without circumferential defect
 - b: with circumferential defect
 - B: involving (sub)total urethra
 - a: without circumferential defect
 - b: with circumferential defect
- Type III: miscellaneous, eg ureteric fistula

Few other Classifications

-according to size

- **small** < 2 cm
- **medium** 2-3 cm
- **large** 4-5 cm
- **extensive** \geq 6 cm

TYPE I



Not involving the
closing mechanism

TYPE II A a

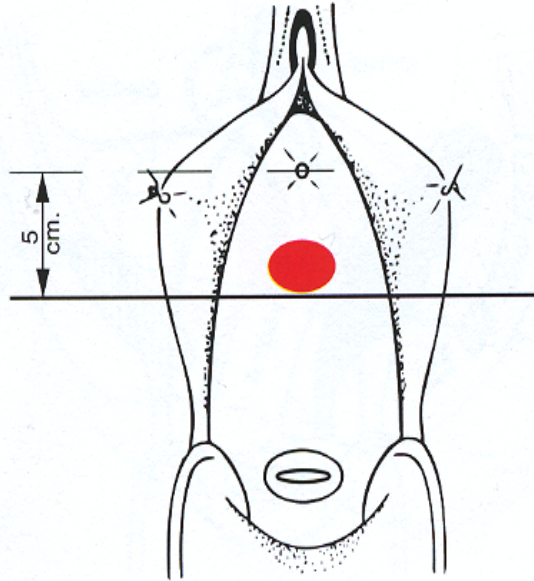


Figure 60-c Urethrovesicovaginal fistula

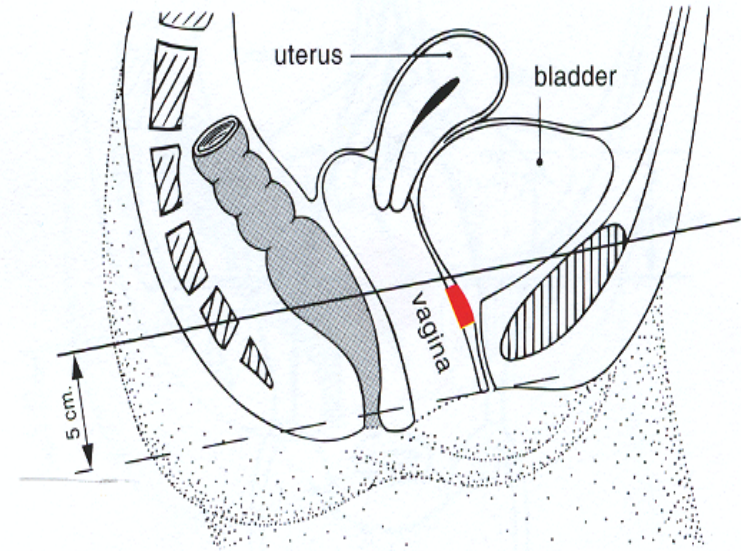
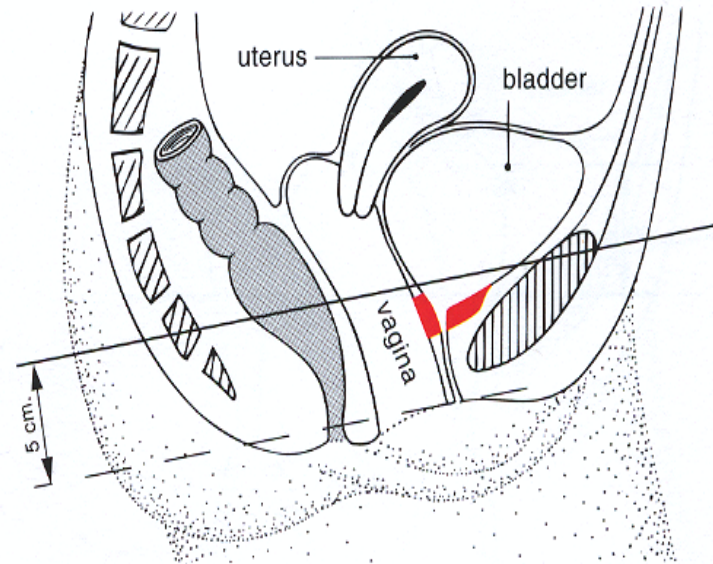
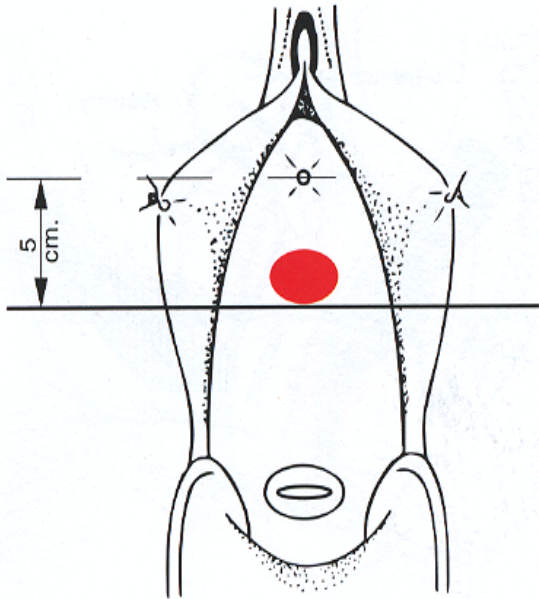


Figure 60-d Urethrovesicovaginal fistula

II Involving the closing Mechanism
A : Not involving (sub) total urethra
a : without circumferential defect

TYPE II A b

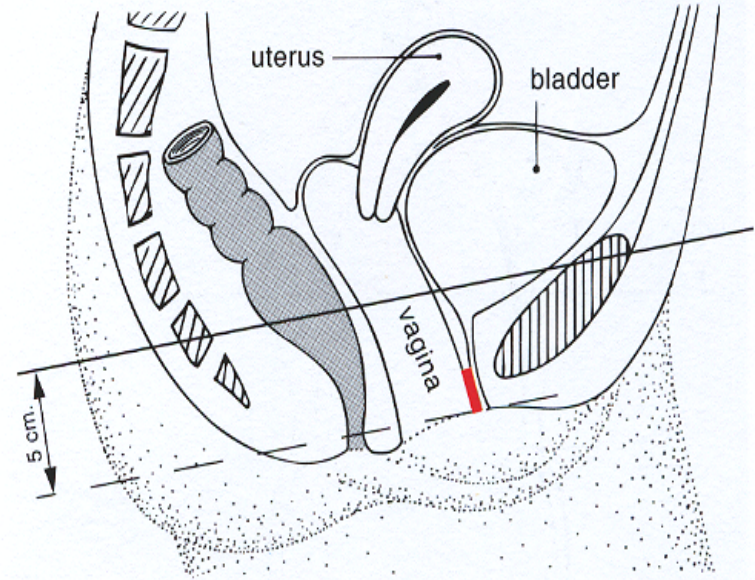
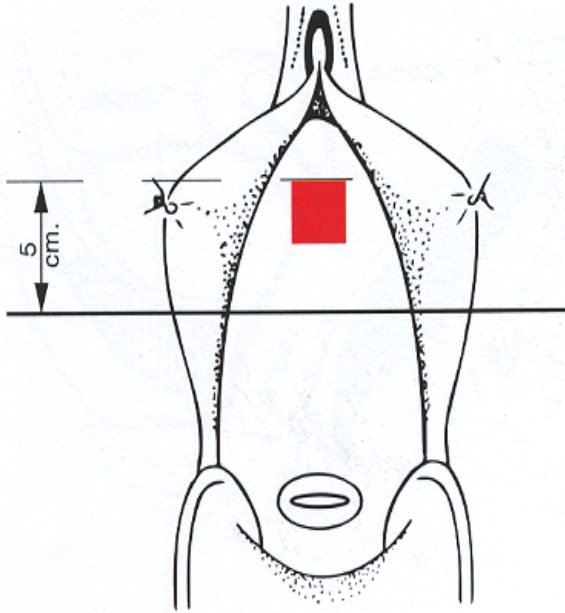


II: Involving the closing Mechanism

A: Not involving (sub) total urethra

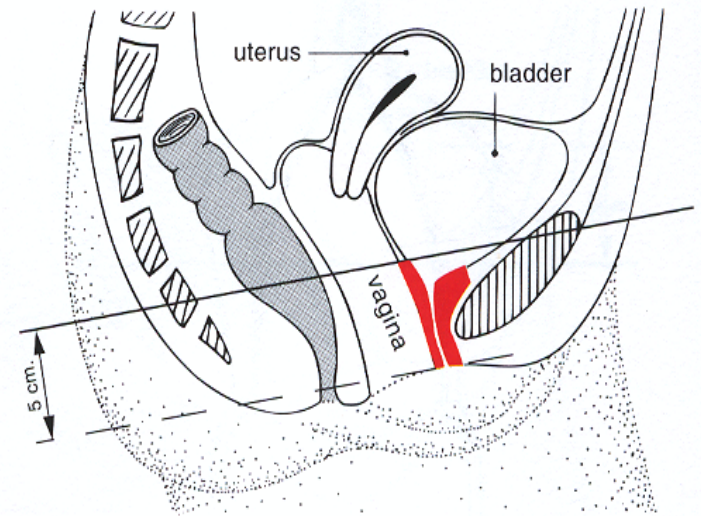
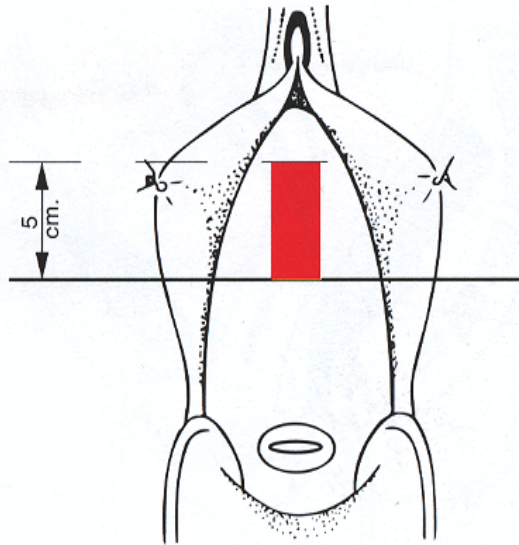
b: with circumferential defect

TYPE II B a

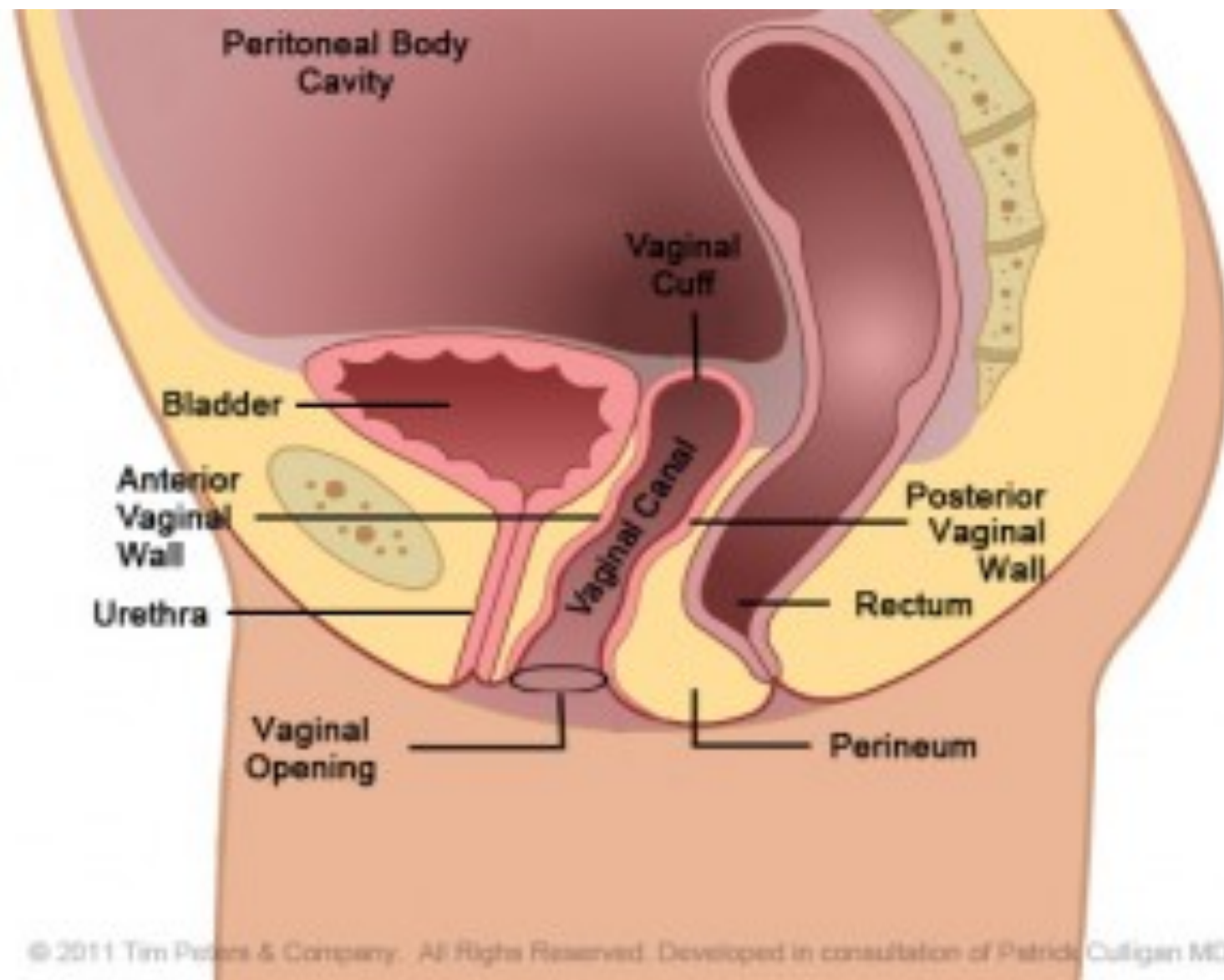


II: Involving the closing Mechanism
B: involving (sub)total urethra
a: without circumferential defect

TYPE II B b



- II: Involving the closing Mechanism
- B: involving (sub)total urethra
- b: with circumferential defect



RVF CLASSIFICATION

I Proximal fistula

- without rectum stricture
- with rectum stricture
- with circumferential defect - very seldom

II distal fistulas

- without sphincter ani involvement
- with sphincter ani involvement

III miscellaneous, e.g ileouterine fistulas after instrumental abortion

- An additional classification is made to the size: small, medium, large and extensive,

Etiology - causes

- Congenital malformation-ectopic vesicae
- Obstetric-necrosis due to obstructed labour, the obstetric fistula
- Surgery: hysterectomy, colporrhaphy, cesarean section
- Vacuum delivery
- Malignancy-cervical cancer, bladder malignancy
- Radiation, e.g. cervical carcinoma
- Trauma—RTA leading to # pelvis , anterior episiotomy (yankin gashiri cut)
- Infections-TB, LGV,HIV
- Trauma due to Criminal abortion
- Sexual Assault

Predisposing or associated factors for obstetric fistulae

- Low socio-economic status
- Illiteracy
- Culture/ traditions
- Limited access to medical services due to poverty, distance of health facility, poor access, facilities not able to provide the care
- The Three delays

Profile of obstetric fistula (OF)patient

- Usually primigravida
- Low socio-economic status
- Unemployed
- Young, unmarried
- Small size(cpd)
- Home delivery
- Still birth or neonatal death

Presentation

- History of leakage of urine/stool -details of event-delivery, surgery, abortion, etc
- General examination-legs-muscle power-foot
- Abdominal examination
- VAGINAL Examination in lithotomy position
- Sim's speculum
 - Size, site, number of fistulae
- Dye test if necessary
- Decide on mode of repair
- Investigations- IVU if no dye noted

Obstructed labour as a cause of OF

- Prevent by management of labour with Partograph
- If happens –after delivery –whatever route
- Insert Foley's catheter and maintain 7-10 days depending on the degree of compression
- For stool incontinence –maintain hygiene
- Remove catheter and observe for continence
- If leakage noted –do speculum examination – dye test if necessary –
- Vulval washouts to remove necrotic tissue
- If fistula confirmed and small maintain catheter for upto 4-6 weeks

Necrosis-slough



Immediate management of obstetric fistula

- If it seems to be healing leave catheter in situ
- 50% of small < 2 cms fistulae close with catheter treatment or become smaller –easier closure
- If not healing excise slough and prepare for early closure
- As soon as wound clean perform an early closure
- Mobilize patient at all times
- Attend to the other needs of the patient

Immediate management of obstetric fistula

- Increased oral fluid intake of 6-8 litres/24hrs
- Ensure free urine drainage
- No routine antibiotics since it is pressure necrosis
- Physiotherapy -Immediate mobilization of patient
- oral iron preparations, vitamins
- high protein diet

Surgery for OF

- Vaginal or abdominal route
- Usually spinal anesthesia
- Episiotomy if necessary
- Wide dissection
- Repair of fistula in one layer
- Dye test
- Closure of vaginal mucosa
- Abdominal –open bladder for ureteric re-implantation

Exaggerated Lithotomy Position- surgery under Spinal anaesthesia



Post op care/Follow up

- Retain catheter for 14 days
- Increased fluid intake > 5litres daily
- Avoid coitus for 6 months
- clinic follow up-2 weeks –dye test if negative remove catheter
- If positive consider retaining catheter for further 2-4 weeks
- Future deliveries by c/section

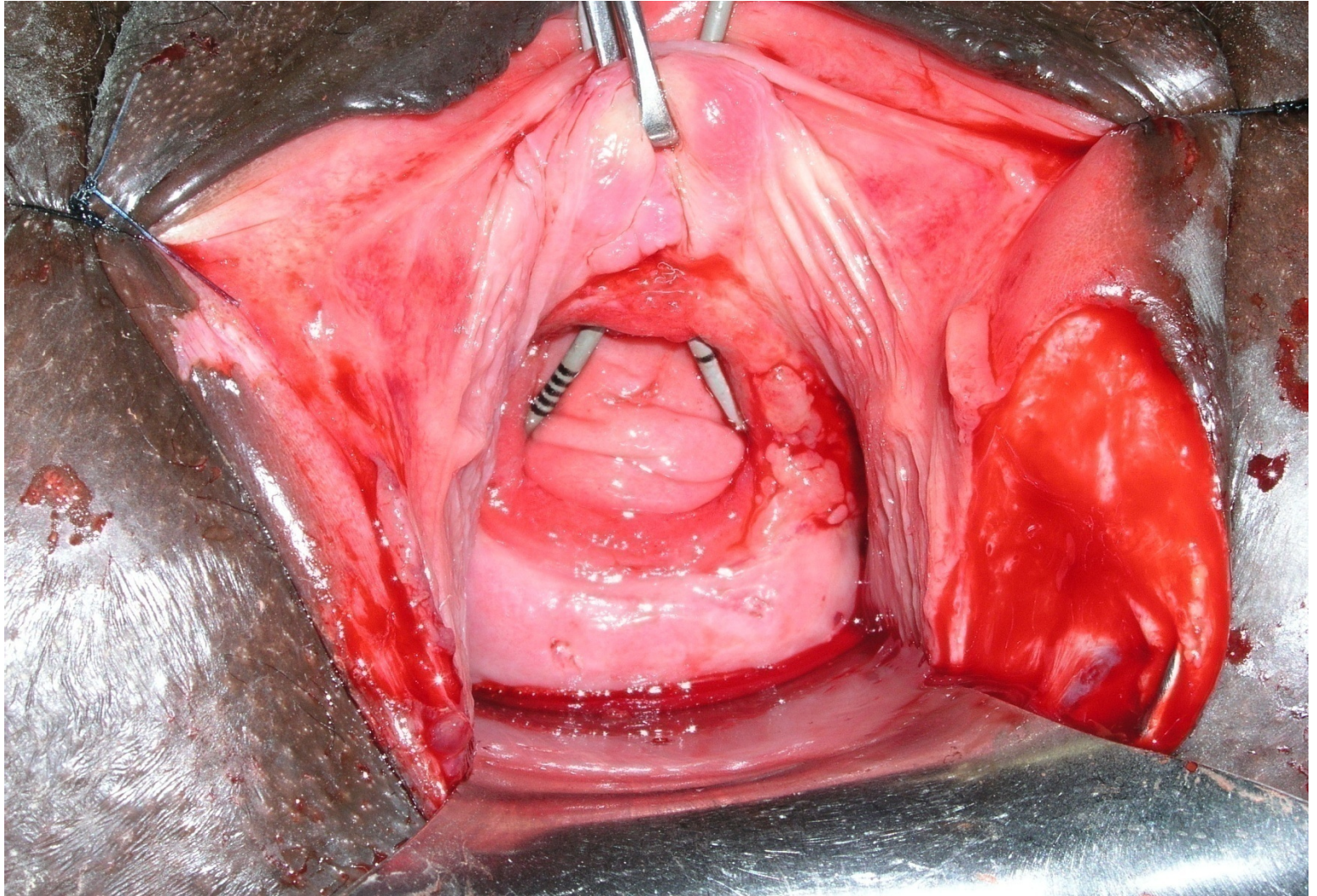
Complications

- Intra-operative
 - Creation of another fistula
 - Ligation of ureter
- Post-operative
 - Break down of repair
 - Blocked catheter
 - Incontinence after anatomical closure of fistula
- Failure to achieve complete closure of fistula

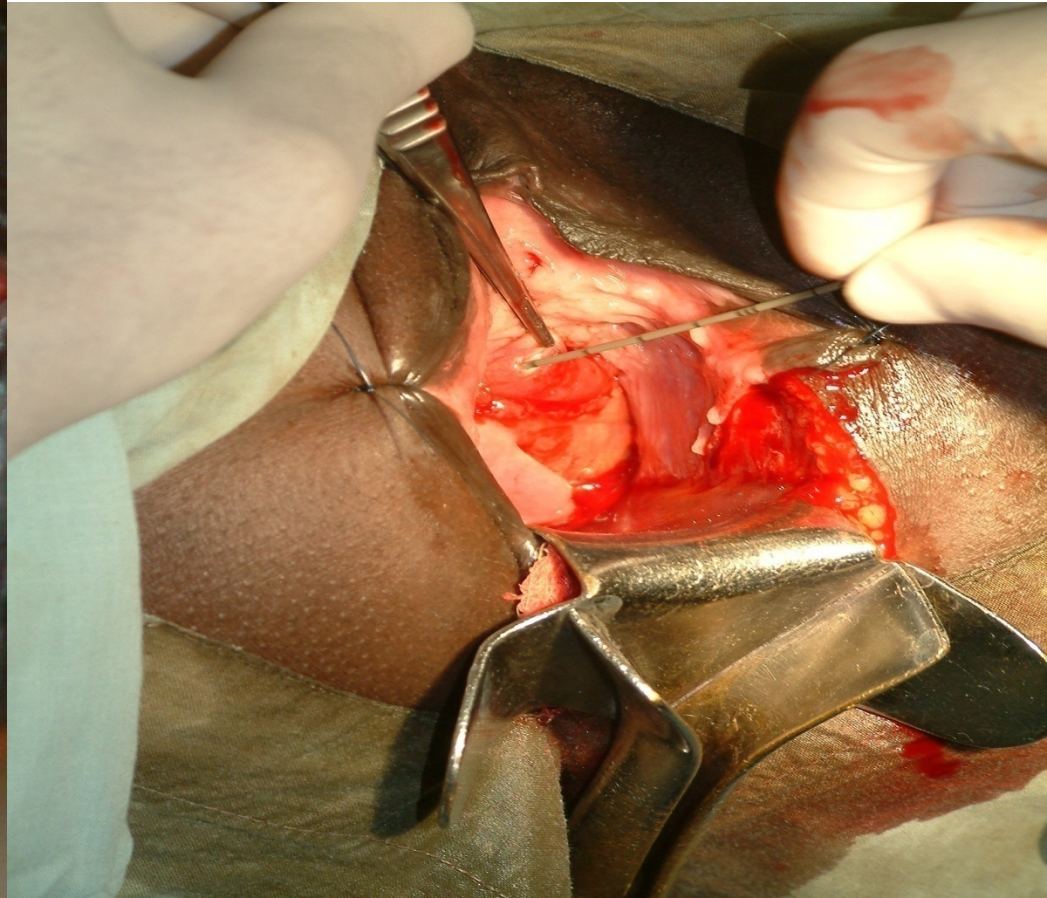
Other surgical procedures

- Re-implantation of ureter
- Colostomy –if RVF high and later reversal
- Urethralization- lengthening the urethra
- Removal of bladder calculi
- Urinary diversion –ureters are placed in a pouch of sigmoid colon –patient passes (liquid stool-urine and stool mixed) several times a day

Ureteric catheterization



Catheterize ureters to prevent injury



Prevention

- Proper management of labour
- Use of partograph to prevent abnormal labour
- c/section within 1 hour of diagnosis of obstructed labour
- In case of obstructed labour –ensure continuous urinary drainage for 7-10 days irrespective of mode of delivery
- Proper surgical technique-
 - hysterectomy/section, cystectomy, vacuum delivery etc
- Prevention of cervical cancer, criminal abortion, sexual assault

Fistula eradication efforts

- Prevention –safe motherhood programmes
- Outreach programmes
- Trainings on fistula surgery
- Surgical Annual fistula camps
- Fund raising for hospitalization and surgery
- Rehabilitation programmes
- Reintegration into society