



eISSN : 2579-8324 pISSN : 2579-8323

CASE REPORT

A Case Report: Vesico Vaginal Fistula

Rezi Amalia¹, Yulia Margaretta Sari²

1. Urogynecology Division of Obstetrics and Gynecology Department, Faculty of Medicine Andalas University, Padang; 2. Obstetrics and Gynecology Department, Faculty of Medicine Andalas University, Padang.

Correspondence :Rezi Amalia, Bagian Obstetri dan Ginekologi, RSUP Dr M. Djamil, Universitas Andalas, Padang, Indonesia, Email :

Abstract

Background: Vesica vaginal fistula is a part of urogenital fistula wich condition that present fistula between bladder and vagina and make urine mold through vagina. **Case Report:** Nullipara woman, 48 years old, admitted with complaining mold of urine from vagina since ten months ago after seven days having surgery procedure. Complaint appeared seven days after hysterctomi procedure as indication of uterine myoma. The vital signs are normal. On Per Speculum examination, clearly see there are fluids on the posterior fornix. Methylene blue test show result one fistula is at the top anterior of vagina, 6 cm proximal from hymenal ring about 1-1.5 cm. The patient underwent fistulorrhaphy with a vaginal approach using the futh mayo technique **Discussion:** Vesica vaginal fistula usually occur in the development country. Predisposition factors of it caused by hysterectomy procedure, besides trauma during labor and complications of pelvic surgery may also too. Physical and additional specific examination conventionally or minimally invasive like cystoscopy, cystography with contrast can obtain diagnosis, determine the location, size and number of fistula. Surgery is the mainstay therapy for urogenital fistula through trans vaginal or trans abdomen. Approaching depends on knowledge, experience and collaboration with other experts if needed. Surgery is the mainstay therapy for urogenital fistula through trans vaginal or trans abdomen. Approaching depends on knowledge, experience and collaboration with other experts if needed. Surgery is the mainstay therapy for urogenital fistula through trans vaginal or trans abdomen. Approaching depends on knowledge, experience and collaboration with other experts if needed.

Keywords: vesicovaginal fistulae; hysterectomy; futh mayo

INTRODUCTION

Urogenital fistula is a serious complication and is feared by women because it has a profound impact, both physically and psychosocially.² In developed countries, urogenital fistula is rare. It occurs and is more commonly caused by gynecological surgery and radiation therapy. Rarely caused by obstetric procedures. While in developing countries, urogenital fistula is a complication that generally occurs due to obstructed labor.³ The magnitude of the problem of urogenital fistulas in the world is still unclear, but it can be estimated that 2-3 million women in the world live with untreated urogenital fistulas, 95% of which are caused by obstetrics and occurs mostly in Asia and Africa, with increments of 50,000-100.

Urogenital fistula generally occurs in areas that have a culture of marriage and pregnancy at a young age. Chronic malnutrition, cephalic disproportion and malpresentation of the fetal head,



eISSN : 2579-8324 pISSN : 2579-8323

ANDALAS OBSTETRICS AND GYNECOLOGY JOURNAL

Correspondence Address:

Editorial Room for Obgin Emas Magazine, 3rd Floor KSM Obstetrics and Gynecology, RSUP DR. M. Djamil Padang, Jl. Padang Independence Pioneers, West Sumatra 25127

Websites:

<http://jurnalobgin.fk.unand.ac.id/index.php/JOE>

which are not treated by competent medical personnel are also the causes. The causes of urogenital fistulas are classified into two, namely obstetrics and gynecology



eISSN : 2579-8324 pISSN : 2579-8323

Most fistulas are caused by obstetric trauma, hence the term obstetric fistula.⁷ Obstetric fistulas are fistulas caused by complex trauma due to obstructed labor. The term describes the injury that occurs due to the entry of the lower part of the fetus into the pelvic cavity, compressing the pelvic bones, causing hypoperfusion of the surrounding soft tissue which results in ischemia, necrosis, and ultimately leads to a connection between the two pelvic organs. Not all obstetric fistulas are caused by obstructed labour.³ Recent data show that of the nearly 6000 cases of urogenital fistula, 13% are iatrogenic, 80% are complications of obstetric surgery, including cesarean section (57%), hysterectomy due to uterine rupture or other obstetric indications approximately 3 %,

CASE REPORT

A nulliparous woman, 48 years old, presented with complaints of urine seeping from the genitals since 10 months ago. Complaints appeared 7 days after undergoing hysterectomy surgery on the indication of uterine myoma 10 months ago. Complaints felt intermittent, smelled of urine. There is a history of intermittent vaginal discharge. There is no history of fever. There was no history of lower abdominal pain. There was no history of painful urination. There was no history of recurrent urinary tract infections. There was no history of pelvic trauma. There was no history of radiation treatment. There is no history of violence. The patient does not have children. Previously, the patient had a total hysterectomy for uterine myoma indications 10 months ago. During follow-up, it is recommended that the patient be referred to a urogynecologist.

CLINICAL FINDINGS

Vital signs within normal. On laboratory examination, complete blood count, ECG, and chest X were found within normal limits. On inspeculo examination, there was a urinary pole in the posterior fornix. Methylene blue test showed 1 fistula at the top of the vagina, 6 cm proximal to the hymenal ring with a size of 1-1.5 cm.

DIAGNOSIS

From the results of the physical and supporting examinations that have been carried out, the patient was diagnosed with a vesicovaginal fistula.

TREATMENT

The patient underwent fistulorrhaphy with a vaginal approach using the futh mayo technique.



Figure 1. Post Operation

DISCUSSION

The most common cause of vesicovaginal fistula is gynecological surgery. Hysterectomy is the most common cause of vesicovaginal fistulas. About 80% of cases occur in developing countries. Patients with a diagnosis of vesico vaginalis fistula were established based on the presence of urine seeping out of the genitals. Smells urine. The patient had a history of postoperative total hysterectomy for uterine myoma indications ten months ago. Symptoms appeared seven days postoperatively. In this case, the cause of the vesicovaginal fistula was a hysterectomy.⁹

The classification of urogenital fistulas is generally grouped into four types; vesico-uterine, vesico-vaginal, urethro-vaginal and uretero-vaginal. Fistulas can appear in certain locations, numbers, sizes and other complications. 75% of cases of vesicovaginal fistula arise due to complications after transabdominal or transvaginal hysterectomy. Fistula can close spontaneously when small size, quiet surrounding tissue and minimal cicatricial.^{5,6}

The diagnosis of a vesicovaginal fistula can be made by clinical symptoms, vaginal examination, diagnostic tests using a dye test (eg, indigo carmine or methylene blue in sterile water) or milk (eg, sterile infant formula), can be used to fill the bladder through a catheter. transurethral. When a vesicovaginal fistula is present, a colored or milky discharge can usually be seen leaking into the vagina. If the fistula is small, it is possible to place a cotton ball into the vaginal canal, and the patient is instructed to move around to change positions to allow leakage from the bladder into the vagina. When this happens then a blue cotton ball into the vagina. However, if this method fails, or the tampon is wet but there is no staining, an oral pyridium or intravenous indigo carmine method can be used and the presence of ureterovaginal, ureterouterine and ureterocervical fistulas can be determined.^{5,6}

If this examination is not successful, the next diagnostic test is by means of a cystoscopy. Collaborative cystoscopy examination was carried out together with a urologist. Cystoscopy



eISSN : 2579-8324 pISSN : 2579-8323

helps determine the exact anatomic location of the fistula and the relationship of the vesicovaginal fistula to the urethral orifice. This patient was not performed because of the obvious location, large enough size, not multiple, no complications. In cases of more proximal or multiple fistulas, involving the bladder or bladder neck and in cases of complex fistulas that require further treatment, Urogenital Obstetrics and Gynecology specialists will collaborate with Urologists. And the repair operation is done together.^{9,10}

Management of urogenital fistula with a transvaginal approach is only performed on the types of urethrovaginal fistula, vesicovaginal and not performed on ureterovaginal fistula which often occurs as a complication of hysterectomy surgery.

There are several repair techniques for vesicovaginal fistulas. In this patient, fistula repair was performed using the futh mayo technique in spinal anesthesia. Attached 4 pieces of hanging sutures 2 cm from the edge of the fistula symmetrically on the front wall of the vagina. A circular incision is made 1cm from the edge of the fistula, the incision starts from the back and continues forward. The vaginal wall is incised in a circular manner and sufficiently mobilized in all directions by performing extensive preparation of the fistula opening. By clamping and pulling the portio down with the tenaculum, the back pole of the bladder can be more easily prepared from the front wall of the cervix to approach the vesico uterine fold. The area behind the circumcission has a free and wide bladder surface to make it easier to perform layer-by-layer fistula closure sutures. The first sequence is a one-to-one transverse suture with an atraumatic needle and fine thread (Vicryl/Dexon 2-0) to fold the mouth of the fistula toward the bladder and close it. The second set of stitches also crosses the front in the same way and thread as the first set of stitches. The second stitch should be far enough laterally and pass far from the first set of stitches, so that the first stitch is well covered by the second stitch. After the second stitch, a 100ml methylene blue test is inserted into the bladder to test whether it is urine tight so it doesn't leak. Finally, the third series of sutures on the vaginal mucosa are sewn lengthwise with one-on-one stitches using a larger thread, namely Vicryl/Dexon No.0 . Sewing into two layers.

Postoperative care has an important role. After surgery, a suction catheter is placed for 7-14 days, after that the catheter is removed and the bladder muscle is exercised by clamping and opening the catheter every 4 hours for 2 days, then the catheter is removed and the patient is asked to urinate on his own every 4-6 hours and the remaining urine is measured. and can be discharged can the rest of the urine is less than 100 ml. It is not recommended to have intercourse for 3 months postoperatively, given oral antibiotics to prevent urinary tract infections.



Figure 2. Post surgery 2 weeks, methylenes Blue test performed

REFERENCES

1. Srichand P. Urogenital Fistula in Developing Countries. 2016;6(1):1–2
2. Ramphal S, Moodley J. Vesicovaginal fistula: obstetric causes. *Curr Opin Obstetrics Gynecology*. 2006;18(2):147–51
3. Harrison MS, Mabeya H, Goldenberg RL, McClure EM. Urogenital fistula reviewed: a marker of severe maternal morbidity and an indicator of the quality of maternal healthcare delivery. *Maternal health neonatology and perinatology*. 2015. <http://mhnpjournal.biomedcentral.com/articles/10.1186/s40748-015-0020-7>
4. Nawaz H, Khan M, Tareen FM, Khan S. Retrospective study of 213 cases of female urogenital fistulae at the Department of Urology & Transplantation Civil Hospital Quetta, Pakistan. *Journal of the Pakistan Medical Association*. 2010;60(1):28–32
5. WHO. Obstetric fistula. *Womens Global Network of Reproductive Rights* [Internet]. 1991;(37):89. Available from: <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med3&NEWS=N&AN=12317335>
6. Santoso BI. 2002. Urogenital Fistula, *Urogenicology I, Reconstructive Urogenicology Obstetrics and Gynecology FK-UI : Jakarta*
7. Pranata MA. Md. Aswin Pranata: Characteristics of Urogenital Fistula Cases in the Department of Obstetrics and Gynecology, H. Adam Malik Hospital. 2007 USU e-Repository © 2008
8. Singh O, Gupta SS, Mathur RK. Urogenital fistulas in women: 5-year experience at a single center. *Urology Journal*. 2010;7(1):35–9
9. Kohli N, Miklos JR 2007. *Managing Vesica- Vagina Fistula*, Women's Health and Education Center- Urogynology : Boston
10. Riley VJ 2004. *Vesicovaginal Fistula*, available at Emedicine.