

# Reopening Of A Previously Repaired Fistula Following Obstructed Labour: A Case Commentary

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## Abstract

Background: Obstetric fistula is a common problem in Tanzania, with an incidence of about 1200 cases per year.

Case: A 25 year-old female, para 2 with no living children, presented with a history of total urinary incontinence following a difficult vaginal delivery. Prior to this delivery she had a previous history of an obstructed labour complicated by vesico-vaginal fistula (VVF), for which she had had a caesarean section and then a vesical vaginal fistula repair in 2006. A repeat fistula was repaired successfully.

Conclusion: Improvement in a patient's socio-economic status and improvement to infrastructure would contribute greatly to prevention of obstetric fistula.

## INTRODUCTION

In Tanzania, the annual incidence of vesico-vaginal fistula is about 1200 cases per year. In 2000-2001, only about 700 girls and women underwent fistula repair<sup>(1)</sup>. Obstetric fistula is preventable. While obstructed labor contributes significantly to maternal mortality in developing countries, those who survive are no less fortunate obstructed labor for survivors usually ends with a dead fetus and a resulting obstetric fistula. Additionally many women are no longer accepted in their own communities and become outcasts<sup>(3)</sup>.

## CASE

A 25 year-old female, para 2 with no living children, presented with a history of total urinary incontinence for four months following a difficult vaginal delivery. The urine leakage started two days following a prolonged obstructed labor. She denied a history of urinary urgency, and the leakage was not related to increase in intra-abdominal pressure. She denied a history of dysuria, fever, or abdominal pain.

She had labored at home for two days, and then labored at district hospital for a day, where she delivered a stillborn fetus by vaginal delivery. She could not recall the birth weight. She was discharged the following day, never having been catheterized at the hospital.

The patient had had a previous history of an obstructed labor

complicated by VVF, for which she had had a caesarean section and then a VVF repair in 2006 at the Bugando Medical Centre. During all of her pregnancies she had initiated prenatal care however, the clinic was very far from her home, being two hours away by bicycle. The patient lived three hours away by bicycle from the nearest bus stand and the nearest hospital was two hours away by bus. The patient was married and lived on a small farm where she practiced subsistence farming. She was also illiterate.

On physical examination, she had a normal gait, and she was not pale, she was afebrile and had stable vital signs. On abdominal examination she had a sub-umbilical vertical scar on the abdomen, and there was no tenderness or organomegaly. On genital examination there was no excoriation on the external genitalia, but there was obvious leakage of urine at the vaginal introitus, with a palpable hole at the level of the mid-anterior vagina approximately two centimeters in diameter. The cervix was closed, firm, long, and located centrally. The uterus was normal in size, no adnexal mass were palpable and no tenderness was exhibited. A diagnosis of vesico-vaginal fistula was made. The patient's hemoglobin was 9 g/dl.

After extensive counseling, the patient agreed to a VVF repair. She received a soap enema the night prior to surgery. She was given intravenous antibiotics 30 minutes prior to surgery. Under spinal anaesthesia a VVF repair was

performed. Closure of the fistula was confirmed by a negative dye test. The vagina was packed with a vaseline gauze for 48 hours. Post-operatively, she was put on Pethidine and 4 litres of intravenous infusions over 24 hours. No further leakage was noted and she was instructed to drink fluid about 5 litres per day. On day 14 post-repair the catheter was removed. She was then discharged with instructions that she should deliver in a place where elective cesarean section can be done in her future pregnancy and to abstain from sexual intercourse for 3 months.

### COMMENTARY

Vesico-vaginal fistula is a disease of poverty. This is clearly illustrated by this patient, who was illiterate and lived very far away from a health facility. Even when she was finally brought to a health facility, it seems her labour was probably not supervised. Low socio-economic status and poor supervision of labour are factors which predisposed this patient and others like her to develop VVF<sup>(2)</sup>.

The particular diagnosis of VVF in this patient was suspected from the history of leakage of urine without the urge to urinate. This symptom helps to distinguish a vesico-vaginal fistula from uretero-vaginal fistula. The type of fistula was confirmed by a digital examination and a speculum examination without performing a dye test. A more thorough examination was performed under anaesthesia at the time of operation<sup>(3)</sup>.

The current literature does not recommend elective cesarean section in a patient who has had a VVF repair, unless there is an obstetrical indication<sup>(4)</sup>. This is applicable where management of labour is optimal. In our setting this may not be practical because of the shortage of skilled birth attendants and insufficient emergency obstetrical care. In our setting, elective cesarean section is the better option.

In the past antibiotics were prescribed for five to seven days. In this case antibiotics were given once peri-operatively. Post-operatively, ascending urinary tract infection is prevented by maintaining a high urine output<sup>(3)</sup>, thus the patient is encouraged to drink 5 litres of fluid daily.

A small VVF that is less than two centimeter in diameter and discovered soon after delivery, can be managed conservatively by prolonged catheterization<sup>(5)</sup>. This could not be applied to this patient as the diagnosis was made late and there was scar tissue from the previous fistula repair. Spontaneous healing would not have been possible due to fibrosis in the scar tissue<sup>(4,5)</sup>.

Improvement in a patient's socio-economic status and improvements to infrastructure would contribute greatly to prevention of obstetric fistula<sup>(6)</sup>. This patient was counseled about the importance of hospital delivery but because she lived very far from the nearest health facility she presented very late in her labor.

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