LATZKO TYPE OF COLPOCLIESIS OPERATION FOR REPAIR OF VESICO-VAGINAL FISTULA COMBINED WITH McINDOE TYPE OF CONSTRUCTION OF VAGINA

by

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Some cases of technically difficult vesico-vaginal fistulae pose a great problem for local repair. This is due to the location of the fistula which may be less accessible from below, and due to scarring it becomes difficult to mobilise the vaginal tissue from the bladder. Moreover, due to repeated failures in attempt at local repair they become further difficult from the point of view of treatment per vaginam. The abdominal route of repair of these fistulae is equally difficult. This type of fistulae are often met with in cases of post-hysterectomy, particularly, Wertheim's and after post-irradiation. In these groups of cases colpocliesis as a method of repair will be the choice of many a gynaecological surgeon. The main objection that has been raised against Latzko's type of colpocliesis is that the vagina gets extremely shortened and it fails as a functioning organ. Hence, these patients suffer from severe dyspareunia or even fail to be a partner in sexual congress. So in these cases if after a Latzko's type of operation a functioning vagina can be created, it would be the answer for many a technically difficult case. Keeping this in mind the authors tried to attempt a Latzko's type of colpocliesis as a method of repair in two cases and later on at the second sitting a McIndoe type of construction of an artificial vagina was made.

The following two cases will bear out the possibility of such a procedure as a method of treatment in such cases.

Case 1

Vesico-vaginal fistula as a result of attempted vaginal reconstruction in a case with absent vagina and uterus.

Mrs. A. B., aged 22 years, para 0 - 0, married for 4 years, with well developed secondary sex characters, was admitted with the complaints of constant dribbling of urine per vaginam. There was a history of operation for an artificial vagina elsewhere.

On local examination she revealed an absent vagina with a fistula ¾" x ½" in diameter, near the junction of the upper 1/3rd and lower 2/3rd of left labia minora. Presumably this fistula resulted from the attempted previous reconstruction of vagina. On rectal examination — uterus was found to be absent.

On investigation:

1. Blood and urine examination — no abnormality detected.
2. Sex chromatines — positive.
3. Gynaecography confirmed that the uterus was absent and both ovaries seemed to be small in size.

Treatment:

Laparotomy was done first, and it was found that the uterus was absent and the ovaries were rudimentary.

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There were two linear bands of peritoneum from the ovarian tissue to the mid-point between bladder and rectum. The abdomen was closed in layers.

It was decided to perform a Latzko type of repair of the fistula. The operation was undertaken a month after the laparotomy. The fistula was brought into view by two traction sutures on the two sides. An oval incision was made around the edge of the fistula, 1 c.m. lateral to the margin. The area was dissected out for about half an inch. The denuded areas were brought together with interrupted mattress sutures with No. '0' chromic catgut. Second layer of mattress sutures was placed over the first. The outermost layers were sutured by interrupted nylon stitches. A self-retaining catheter was kept in the bladder for fourteen days. Nylon sutures were removed after twenty-one days. There was perfect union of fistula and the patient was found to be continent.

After a lapse of another two months of the above operation, it was decided to construct an artificial vagina by McIndoe method, as the patient was young. After the usual pre-operative preparation the patient was placed in the lithotomy position. The right labium minoris was stretched with an Allis's forceps. A curved incision was made along its inner aspect, the site being opposite that of the site of the fistula (Fig. 1). The incision extended from a point below the level of the urethra up to the fourchette. The incision was deepened through the areolar tissue (Fig. II) and the area was dissected out by digital separation (Fig. III). By this method a sufficiently large area was created between the lateral side of the vagina and the inner wall of the labium minoris. The area was then stretched by two index fingers liberally and a vaginal mould was introduced to see whether it could be harboured easily.

This mould was covered with a skin graft taken from the right thigh (Fig. IV) and was put inside the space created for the mould (Fig. V). The labium minoris was split and the split portion was also tagged with the lower part of the lateral wall of the newly created vagina. The mould was retained in this position and the two walls of the wound were sutured with catgut (Fig. VI).

During the post-operative period a self-retaining catheter was kept in the bladder for four days. The graft with the mould was expelled five days after the operation, but the newly created space was maintained by repeated dilatation even after six months of follow up. Patient is now happy regarding her marital relationship.

Case II

Intractable vesico-vaginal fistula with repeated failure at local repair.

Mrs. S. G., aged 28 years, para: 1 - 0, was suffering from incontinence of urine after her last childbirth. Repair of vesicovaginal fistula was attempted at three centres but failed. The patient also had hysterectomy done for haematometra at one of the previous centres.

On examination it was found that the left side of the vaginal orifice was more or less replaced by a mass of scar tissue whereas on the right side there was a fistula about 1″ by ¾″. The fistula was repaired by Latzko's technique and the patient was continent.

Four months later, a space was created as described in the first case, on the ~~left~~ side between the labia minora and hard scar tissue. A mould with a skin graft was kept in situ for 4 weeks after which the mould was extruded. The post-operative period was otherwise uneventful. The patient had a vaginal space of 2″ and can maintain conjugal life without any gross pain.

Discussion

The above two cases clearly bear out that Latzko's repair of fistula can be profitably undertaken in technically extremely difficult cases. The conjugal function of the patient can be maintained by constructing the vagina on the side opposite to that of the fistula.

But it must be remembered that Latzko's colpocliesis has a very limited scope in the treatment of fistulae. It should be only undertaken in des-

perate cases where a proper local repair cannot be undertaken, due to technical difficulty for excessive scarring, and very limited space of approach. Even a Schuchardt's incision to get accessibility to the fistula will not be very helpful, apart from the fact that the scar tissue will prevent adequate mobilisation of the fistula.

These fistulae are often met with after repeated attempts at local repair which had failed even at the hands of very competent surgeons, as in cases of post-operative vesico-vaginal fistulae, especially after total abdominal or Wertheim's hysterectomy. In such cases a Latzko type of operation is advisable. Some agree that Latzko's operation may be undertaken in a high vesico-vaginal fistula combined with a recto-vaginal fistula. So, in properly selected cases Latzko's colpocliesis has still a place and this place will be further secured if we can maintain a functioning vagina. This technique of combining a McIndoe type of operation with a Latzko is eminently suitable.

As has been described in the first operation, Latzko type of operation will be done at the first sitting. If the patient becomes continent, a McIndoe type of operation may be undertaken. The incision for the McIndoe type should be opposite to that of the fistulous margin and is a longitudinal one, starting from the lower part of the urethra up to the end of the labia minora. The mould may be kept in without even a skin graft. Modifications of McIndoe's operation were done at several points. The incision was vertical and the space created on the lateral side. Williams (1964) described such an incision for congenital absence of vagina. This incision is suitable in the groups of cases already described. When the split labium minoris will be sutured to the lower part of the incision there will be epithelialisation of the vagina. Even if the mould with the graft is extruded it can be realised from the first case that a space can be maintained by repeated dilatation at the beginning with dilators by the patient, and later on by conjugal relationship with full satisfaction.

Summary

1. The scope and limitations of a Latzko's method of colpocliesis in intractable vesico-vaginal fistulae are stressed.

2. The limitation can be overcome by the creation of an artificial vagina with McIndoe type of repair.

3. Two such cases were performed by the authors.

4. The advantage of this operation has been stressed.

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Figs. on Art Paper IV-V