VESICO-VAGINAL FISTULA†

by

A. V. NARAYAN RAO,** M.D.

Patients suffering from vesico-vaginal fistulae, having the medical, social and psychological handicaps, were relieved through the successful operative technique practised by J. Marion Sims, in 1849. Naguib Mahfouz Pasha, in Egypt, T. Coetzee, in South Africa, J. C. Moir, in England and Lazarus, Naidu, Krishnan and Subhadra Devi in India, reported their experience of a large number of cases. The cure rate was almost 100% in Moir's series, 88% in Naidu's series and 51.6% to 86% urethral to high vaginal fistula in Coetzee's series. In our series of 66 cases, cure rate was 60 to 73%.

Aetiology:- Obstetric trauma due to prolonged, obstructed labour and operative delivery account for a high percentage of cases in India and other backward countries, whereas gynaecological surgery accounts for increase in percentage of fistulae in the advanced countries. In Moir's series, 27.4% of fistulae were obstetric in aetiology and 72.6% gynaecological, in Naidu's series 201 to 208, 96.6 per cent of fistulae were obstetric in origin. In our series of 60 cases of obstetric origin the aetiological factors were prolonged labour 32 cases, forceps 20, transverse lie 6, and rupture uterus 2. In the 6 gynaecological cases the causes were vesical calculus, abdominal hysterectomy, application of caustic, wood apple in vagina for prolapse, bullgore injury, and tuberculosis of bladder one each.

TABLE I

Fistula Type

Pelvic type	Juxta-urethral	Mid-vaginal	Juxta-cervical	
Generally contracted	6	5	1	= 12
Ricketty flat	6	7	1	= 14
Android	2	2	—	= 4
Anthropoid	3	2	—	= 5
	17	16	2	35

Radiological examination of pelvis in 35 cases revealed no apparent relation of the type of fistula to the shape of the pelvis, with flat and gynaecoid pelvis having equal incidence, as shown in Table I.

*Prof. of Obst. & Gynec., Kurnool Medical College, Kurnool.

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Radiological pelvimetry showed the following diameters at three pelvic levels:-

	Antero-posterior diameter	Transverse diameter
Inlet	9 to 11.5 cm	10.5 to 12.5 cm
Cavity	8.5 to 11 cm	6.5 to 9 cm
Outlet	5 to 7.5 cm	7 to 10 cm

Pregnancies following repair of fistulae

There were 27 cases of pregnancy following repair of fistula (residual fistula in 3 cases) and in 5 cases with a fistula not operated on earlier. The conception rate in the cured cases was 18 out of 66 (24%). The type of fistula repaired in the cases who became pregnant was juxta-urethral 10, mid-vaginal-2, high vaginal-3 and 12 not recorded. Nineteen cases were delivered by caesarean section and 13 had vaginal delivery; 10 of the babies delivered by caesarean section were premature (1 below 2 Kg) and 6 of the babies delivered vaginally were premature, (3 below 2 Kgs.). The incidence of prematurity was 16 in 32 cases (50%) and of caesarean section 59%. The perinatal mortality was 20% (6 out of 32 cases) with 2 stillbirths and 4 neonatal deaths.

The contractions in the initial stage were weaker than normal and the patients were found to be advanced in the first stage by the time they came under observation. As pointed out by Naidu those cases with marked destruction and shortening of the anterior vaginal wall and deformity of the cervix were found to have premature labour. The incidence of prematurity may be due to other factors like malnutrition, lack of antenatal care and rest, besides injury and deficiency of vesico-vaginal septum due to scarring. Prematurity and multiparity account for the high incidence of vaginal delivery following repair of the fistula.

The high incidence of vaginal delivery (10 out of 27 case), in cases of repaired fistula, is in contrast to others who routinely perform caesarean section. There was no case of recurrence of fistula following vaginal delivery. Among the 8 cases of contracted pelvis with fistula, 5 were delivered by caesarean section and 3 delivered vaginally.

A case of Naegale's pelvis with a big vesico-vaginal fistula following a difficult labour of four days, is given. N. aged 23, primipara, was admitted on 26-12-'63 with hisotry of dribbling of urine since 6 months. A large mid-vaginal fistula about 3 inches wide with prolapse of bladder mucosa was present. The fistula was repaired on 31-1-'64 by flap-splitting operation using No. 00 chromic catgut and she was discharged on 8-2-'64 with a residual pinpoint fistula. On follow-up examination on 19-8-'64 she was found to be completely cured with no dribbling of urine, and the pinpoint fistula closed spontaneously. X-ray of the pelvis showed typical features of Naegele's pelvis with absence of sacro-iliac joint, narrow sacro-sciatic notch, aplasia of sacrum and a straight iliopectineal line on the right side.

Summary

The incidence, aetiology of 66 vesico-vaginal fistulae, radiological examination of pelvis in 35 cases, pregnancy after repair of fistula and conduct of labour in 27 cases were studied during 1961-64. One case of Naegele's pelvis with vesico-vaginal fistula following a difficult labour is reported.

Figs. on Art Paper I