V. V. FISTULA REPAIR IN AN UNUSUAL WAY

By

P. B. Pai Dhungat,
S. R. Goyal and V. Darade

Introduction

The methods used for the repair of urinary fistulae are legion.

Herein we are presenting a case report wherein the part of the uterus left behind after doing subtotal hysterectomy for rupture of the uterus was incorporated in the bladder with successful result regarding incontinence and also increasing the bladder capacity.

This is a unique method, as no such other method has been presented upto now either in text books or any of the Journals.

CASE REPORT

A middle aged lady of about 33 years of age presented to us with continuous dribbling of urine since 6 months.

6 months back the patient had full term delivery. Delivery was normal with labour pains starting in the afternoon and patient delivered in the evening. It was a normal delivery without any intervention. There was no H/o giving any uterine stimulating drugs. After the delivery of the baby, patient had severe PPH and became unconscious. The patient was given blood transfusions and was transferred to OT. The patient's Obstetrician diagnosed rupture of the uterus and laparotomy was done. On Laparotomy they found that there was rupture of the uterus as well as of the bladder. Hence subtotal hysterectomy was done and the bladder was sutured as much as possible at that moment. Foley's catheter was put for 14 days. On 15th day, catheter was removed. Patient was apparently alright on the 15th and 16th day when she used to pass urine frequently in little quantity. On 18th day the patient found that urine was dribbling out continuously. So Foley's catheter was put again for another 21 days. But after removal the patient was dribbling urine out. This patient presented to us with the above complaint.

Obstetric history—patient was Gravida—8 and Para—5. Patient had 3 abortions at 2nd and 3rd month. She had one stillbirth which was a home delivery and four full term normal deliveries. Last delivery was 6 months back. Patient has not got the periods since then and patient is not lactating. On systemic and general examination, everything was normal except for presence of anaemia.

P/S examination—urinary dribbling was present. On swabbing the vagina dry post lip of the cervix was seen which was congested. Vaginal walls were pale. There was a rent in the anterior vaginal wall in upper 1/3rd area through which urine was seen dribbling out. Bladder mucosa was not seen.

ut—not felt on per vaginal examination
cx—hard post lip
Vagina—Rent in upper 1/3rd of anterior vaginal wall with surrounding induration.

The patient was investigated. Her all investigations like CBC, Blood Urea, Creatinine, Sugar, SMA 12 + 2, ECG, chest X-ray were normal except for U T I—urine showed 20-40 pus cells. I.V.P. was done which showed normal excretion of dye from both the kidneys and normal filling of pelvis. There was a vesicovaginal fistula as shown in **Plate No. 1.**

Plate 2 shows cervicovesicovaginal fistula diagramatically.

Patient was then taken for cystoscopy. During cystoscopy all the saline was draining out from the fistula hence the ureteric openings could not be visualised. We tried to put uterine sound in the uterus through the fistula. It used to go about 1" in uterus posteriorly and 3" in bladder anteriorly as shown in **Plate No. 3** diagramatically.

The patient's general condition was improved by giving high protein diet and blood transfusions. The patient was then taken for repair of VVF.

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Bladder was dissected and separated from vaginal mucosa.

Excision of anterior edge of the cervix was done and saucerization of the fistula edge was done upto the posterior lip as shown in **Plate No. 4.**

Bladder mucosa was sutured by chromic four zero catgut upto the post lip of cervix as shown in **Plate No. 5.**

Fascia was sutured.

Vaginal mucosa was sutured.

Hence the part of uterus which was remaining was incorporated in the bladder so as to increase the bladder capacity as shown in **Plate No. 6.**

CERVICO VESICOVAGINAL FISTULA

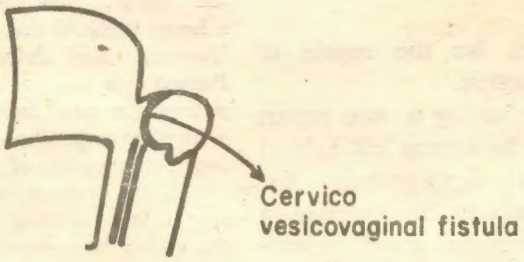

Fig. 2

SOUNDS GOING IN BOTH CAVITIES THROUGH FISTULA

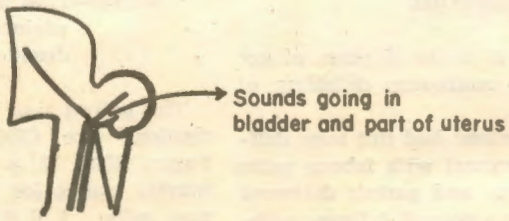

Fig. 3

EXCISION OF ANT LIP OF CERVIX & SAUCERISATION

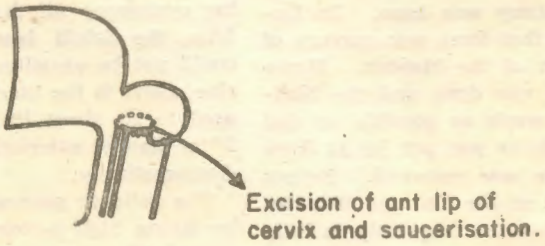

Fig. 4

FISTULA STITCHED IN TWO LAYERS

Fig. 5

FINAL RESULT

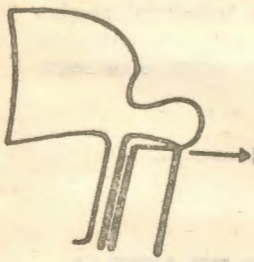

Fig. 6

Post op. — Foley's catheter was put for 14 days. On 15th and 16th day catheter was clamped and patient was advised to pass urine every 3rd or 4th hour so as to train the bladder.

Catheter was removed on 17th day. Patient is now able to pass urine every 3rd and 4th hour and is symptom free.

I.V.P. was done again which showed no fistula, as shown in **Plate No. 7.**

See Figs. on Art Paper II

PUBERTY MENORRHAGIA DUE TO VON-WILLE-BRAND'S DISEASE

By

S. DHANALAKSHMI AND
SHIELA RAJARATHINAM

Introduction

In cases of puberty menorrhagia investigations are carried out to diagnose anemia, systemic diseases, defects of coagulation and bleeding. These are mandatory to treat the patient accordingly.

We present here our classic case of puberty menorrhagia due to Von Wille Brand's. The following features are diagnostic of Von Wille Brand's of which available investigations were done.

(a) Prolonged bleeding time. (b) Defective platelet adhesiveness. (c) Normal aggregation of platelets by collagen, ADP, epinephrine or thrombin but abnormal aggregation by Ristocetin. (d) Very low levels of VIII C, VIII Ag and VIII VW and (e) Hyper response following infusion of normal cryoprecipitate. The procoagulant activity is measured by the traditional clotting assay for factor VIII.

The inheritance of Von Wille Brand's disease was originally described as autosomal dominant because both sexes were affected and transmission appeared to be through an affected parent.

CASE REPORT

(1) Miss K. aged 17 years admitted on 27-5-86.

Presenting symptoms

Bleeding PV—20 days.

Bleeding gums—1 1/2 years.

Bleeding PV 20 days in a cycle since menarche. Heavy bleeding with passage of clots.

From: Government Stanley Medical College, Madras.

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She also has bleeding from gums. On trauma H/O increased bleeding from the wounds which stops only on suturing and spontaneously occurring echymotic patches which regressed on their own No haematuria, melena, joint swelling, no family history of bleeding disorder, diabetes mellitus, tuberculosis, hypertension.

Physical Findings

Thinly built girl, not in distress, severe pallor, no purpuric spots, icterus, edema or lymphadenopathy. Pulse 100/mt. Regular pressure 110/80 Cardio vascular, Respiratory, Central Nervous system and abdomen —NAD. P.R.—uterus normal size. Fxs free.

(1) Complete Blood counts

Haemoglobin—5.6 gm%
Packed cell Volume—18%
Blood Picture—
Anisocytosis +
Hypochromia +
Poikilocytosis +
Polychromasic +
Nucleated RBC 1/100 WBC.
Occasional Giant Platelets.
WBC Count—Total 8,000 cells/cm

Differential counts:—
Myelocytes 2%
Band forms 2%
Neutrophics 60%
Basophics 4%
Lymphocytics 31%
Monocytes 1%

Bleeding Time—More than 15'
Clotting Time—21'
Clot Retraction—Good.

Partial Coagulation Time	Control	Patient
(a) Prothrombin Time	12"	11.5"
(b) Partial Thromboplastin Time	71"	119"
(c) Plasma clotting Time	159"	275"
(d) Thrombin Time	5.5"	5.5"

(2) Total Proteins — 6.7 gms
Albumin — 4.1 gms

(3) Tests of Fibrinolysis:—
(a) Plasma fibrinogen—280 mgm%
(b) Clot lysis — Nil
(c) Euglobulin lysis Time—control Pt, 2 hrs. 30 mm; Patient—4 hrs. 45 min. Factor XIII Activity—Normal.
(4) Blood Group—AB.
Typing—Rh +ve.
(5) LE Cells — Negative.
Chest X-ray within normal limits.

This anemic girl with Hb 5.6 gms was transfused 2 bottles of compatible blood and also AHG concentrate in cryoprecipitate. To control vaginal bleeding primolut-N 10 mg daily given for 20 days from D5 to 25. At discharge after 2 weeks her Hb was 8.1 gms and bleeding had been under control.

This girl went back to her native place at Thirupathur on 20-6-86 to come back after 7 months in February 1987 again with menorrhagia and anemia. She was transfused another bottle of AB/+ve blood and cryoprecipitate with AHG. She reports and writes to us regularly.

A CASE REPORT OF BILATERAL TUBAL PREGNANCY

By

L. RANJIT SINGH AND A. LILABATI DEVI

Introduction

Bilateral tubal gestation is the rarest of double ovum gestation. The incidence varies from 1:725 to 1:1580 of ectopic pregnancies.

CASE REPORT

Mrs. C. K. Devi, 27 years old, Gl Po + O + O + O had acute pain abdomen and vaginal

From: Department of Obstetric and Gynaecology, R.M.C. Imphal.
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V. V. Fistula Repair in an Unusual Way—Pai-Dhungat et al pp. 727-729

Fig. 1
V. V. Fistula as shown on I.V.P.

Fig. 7
No Fistula seen on I.C.P. after repair.

Vesical Calculus with Complete Prolapse of Uterus—Meenalochani & Jeylakshmi pp. 734-735

Fig. 1
Shows vesical calculus with complete prolapse of uterus.