"Vesico-Cervical Fistula Following Caesarean Section" - a case report.

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V. V. F. of obstetric aetiology is still not very uncommon in our country. But Vesico-cervical fistula are not that common. Here we report an interesting case of vesico-cervical fistula which developed following LSCS.

Mrs. P. B., 30 years, H/F, P_2+O, living issue-one, was admitted on 22/1/97 in G&O Dept. of B. S. Medical College, Bankura, with C/o continuous dribbling of urine per vagina since her last child birth by emergency LSCS in 1989 (detailed records not available). The baby died one hour after birth. She had her first baby (living) delivered normally in 1986.

She could also pass urine on urge via urethra. She had haphazard O.P.D. treatment in between without any benefit.

After her admission, 3 swab test showed staining of upper most swab with dye. Speculum examination revealed dribbling of dye stained urine through external os. On HSG radio-opaque dye was seen to enter inside bladder through a fistulous communication between cervix and urinary bladder. The uterus and tubes were normal with peritoneal spillage (vide Fig. I).

After routine pre-operative work up surgical correction through abdominal route was undertaken on 28/1/97. On opening the abdomen, urinary bladder was found to be densely adherent to the isthmus and anterior wall of cervix. During dissection, through utero-vesical pouch of peritoneum, to seperate the bladder from isthmus and cervix the postero-superior surface of bladder wall was opened up exposing the cavity.

Ultimately bladder could be separated but along with it left lateral wall of cervix upto left cervicovaginal junction was also opened up exposing the cervicovaginal canal. No separate fistulous tract could be detected. The fistula probably developed due to inclusion of bladder wall in the repair of the extended tear of left angle of the uterine incision downward upto left cervico-vaginal junction during the previous caesarean section. The extension of uterine incision probably occurred during disimpacting the head jammed low down in a case of prolonged labour. The death of the baby shortly after birth also justifies such assumption.

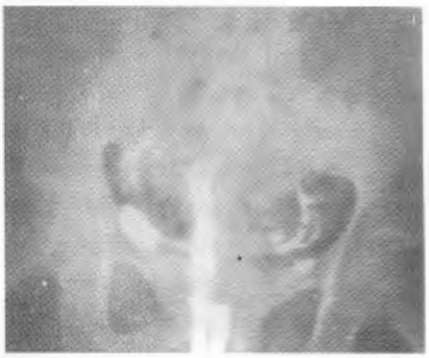

Fig 1: HSG showing Vesico-cervical fistula

The bladder was repaired in two layers by 3-0 atraumatic vicryl. The cervix and cervico-vaginal junction were closed by interrupted sutures with 1-0 atraumatic vicryl. Before closing the abdomen water tightness of repaired bladder was tested by pushing methylene blue dye into the bladder.

Post-operatively continuous bladder drainage for 15 days was instituted by 14F Foley's catheter. Antibiotics were given. On removing the catheter after 15 days the patient was alright without any urinary problem. She was discharged on the 17th day in a happy mood fully cured from her distress.