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An Unusual Rare Case of Post MTP Vesicocervicovaginal & Enterovesical Fistulae:- Repair by Combined Abdominovaginal Approach

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A 30 years old lady named Pushpa was referred to Medical College, Gwalior from a peripheral centre, with history of MTP & conventional tubal ligation operation done 1 ½ years back. Few days after the operation she started passing urine pervaginally and the urine was sometimes mixed with stools. Following MTP she also underwent laparotomy and temporary colostomy, but could not tell the cause.

On local examination, a high vesico-vaginal fistula was seen anteriorly at cervicovaginal junction of 1cm x 1.5 cm. On passing uterine sound it could be seen through the fistulous opening suggesting a co-existent cervico-vesical fistula. On per vaginum examination her uterus was normal sized fixed retroverted with palpable adnexae.

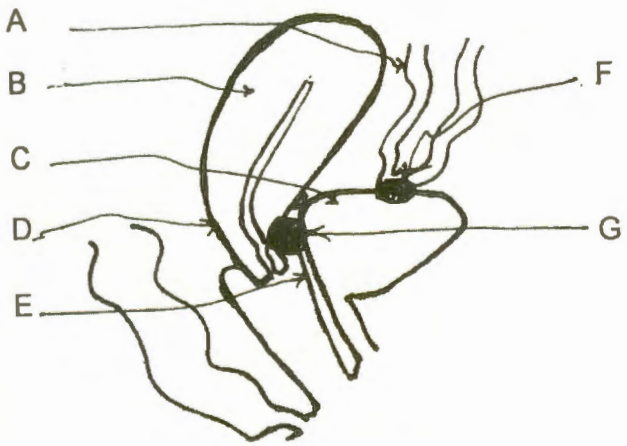

Fig. I: Diagrammatic representation of vesico-cervicovaginal & entero-vesical fistulae

A - Intestines
B - Uterus
C - Urinary bladder
D - Cervix
E - Anterior vaginal wall
F - Entero vesical fistula
G - Vesico-cervico-vaginal fistula

Her IVP showed bilateral normal functioning kidneys & ureters. On micturating cystourethrography, dye could be seen leaking out posteriorly indicating associated entero/rectovesical fistula. On cystoscopy two big fistulae seen in the bladder both lying above the trigone (Fig. 1).

A combined surgical approach using both abdominal & vaginal routes was decided. (Fig. 2)

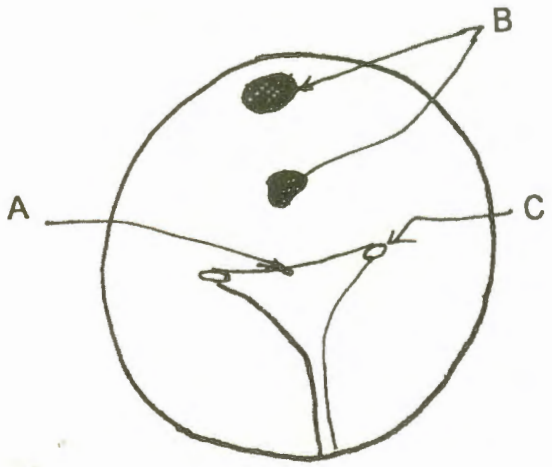

Fig. II: Cystoscopic view of the vesical fistulae

A - Trigone
B - Fistulae
C - Ureteric openings

Through vaginal route, edges of the fistulae were grasped with fine allis forceps and incised in an inverted V-shape. With sharp and blunt dissection, urinary bladder was separated from the anterior surface of the cervix and mobilized upwards, so that cervical fistula was cleared off the bladder. Further mobilization of the bladder was not possible because of dense adhesions between the base of bladder and anterior surface of the uterus.

Patient's abdomen was then opened. There were numerous intra-abdominal adhesions. Loop of intestine was adherent to the dome of the urinary bladder forming intestine-vesical communicating fistula which was gently separated leaving a hole of 3 cm. diameter in the ileum. It was repaired in double layer using No. 3-0 silk.

After opening vesico-uterine fold of peritoneum, base of the bladder was gently dissected from the anterior surface of the uterus, and edges of the vesico-cervico-vaginal fistula mobilized.

Urinary bladder was then opened between two stay sutures. Bilateral ureters were catheterized with No. 5 ureteric catheters, freely draining urine.

Edges of both fistulae, were freshened, one at the dome of 3 cm diameter & other at the base of 5 cm diameter, repaired separately in double layer with No. 3-0 vicryl. Bladder was closed over intravesical Malecot's catheter.

This was followed by total hysterectomy, vaginal vault closed & abdominal wall closed in single layer. Indwelling foley urethral catheter was also inserted.

Postoperative period went smooth. Malecot's catheter was removed on 14th day and Foley's catheter removed on 21st day. On discharge patient was continent and dry.

Three monthly follow up was done. Patient had no leakage.

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