An Unusual Case of Vesico – Cervico Vaginal Fistula

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Genito-urinary fistulae are a rare occurrence today. A 43 year old lady, Mrs. M., hailing from an urban area, who came to us on 1st July, 99 with the distressing complaint of continuous dribbling of urine. This problem started in the immediate postop period of her 3rd caesarean section (done after the onset of labour). According to her an indwelling urinary catheter was kept for 14 days, but was removed as leakage of urine persisted. She was also amenorrhoeic since then. Her obstetrical history, in todays context, was disastrous. She was 8th para with one living issue. The first four pregnancies ended in preterm stillbirth. 5th was LSCS for transverse lie & the baby survived. 6th was LSCS for previous LSCS with IUGR & baby died after one month. 7th was a preterm vaginal still birth. 8th was the last LSCS for 2 previous LSCS with labour pains after which her urinary dribbling started.

She was short statured & of thin built with unremarkable general & systemic examination. Abdomen revealed subumbilical midline vertical scars. Vulva showed no excoriation. On per speculum examination, there was absence of anterior lip of cervix. Urine was seen coming through the groove between the vagina & the posterior lip of cervix. Per vaginal examination confirmed absence of anterior lip of cervix with a hole of 1.5 cm diameter admitting finger-tip into the bladder. Uterus was normal sized & fornices were clear. Diagnosis of vescico-cervico-vaginal fistula was made which was confirmed by the 3 swab test. Routine haemogram & KFT were normal. IVP showed normal functioning kidneys on both sides & evidence of vaginal leak. Cystoscopy showed a fistulous opening above the trigone on the posterior wall of bladder. Total abdominal hysterectomy along with fistula repair by transperitoneal approach was planned.

Under spinal anaesthesia abdomen was opened by subumbilical midline incision. Uterus & adenexae were normal. Bladder was separated from lower part of uterus & isthmus by sharp dissection, which exposed the fistulous opening in bladder 2 cm x 2 cm, communicating with vagina, anterior part of cervix was absent.

Total abdominal hysterectomy was completed & vaginal vault closed with No.1 – 0 vicryl. The well separated bladder opening was freshened & closed with No 3 – 0 vicryl by interrupted stitches in 2 layers. Pedicle omental graft was attached. Suprapubic cystostomy with Malecot's catheter was done before closing the abdomen. Foley's catheter per urethra was also introducted for double drainage. Catheters were removed by 14th postop day & patient was fully continent.