

COMMENTARY ON THE FILM DESCRIBING FISTULA SURGERY AT THE ADDIS ABBA FISTULA HOSPITAL

Please read this before viewing the film



Dr Brian Hancock with Sebastian, his anaesthetist

Please note that these videos show the methods used at the fistula hospital in 2000.

The figure quoted of 95% success refers to the closure rate, not the cure rate. This figure is only achieved after re-operating on a small percentage of cases.

Unfortunately many patients have stress incontinence in spite of a closed fistula. Minor cases may recover but at least 10% have long term unacceptable stress. Some may be helped by a second operation.

The methods shown on the video work well in the fistula hospital but viewers should be aware that several other fistula experts have simplified the Addis method without compromising results. Some of these modifications are described now and are particularly relevant to surgeons practicing with limited resources.

PRE-OPERATIVE PREPARATION

Pre-op hydration. As soon as the decision has been made to operate the patient should be encouraged to drink plenty of fluids. Pre op hydration will make it easier to find the ureters, ensure a good immediate post op output of urine and lessen the need for IV fluids.

Enemas are given for two days in Addis, but the nursing care to supervise this is rarely available in other hospitals. Many surgeons do not prescribe enemas, but insist that the patient has had a chance to open her bowels before coming to theatre. In the occasional case of anal soiling during surgery, a temporary anal purse string suture can be inserted.

OPERATIVE DETAILS

Exposure. Some surgeons make more use of episiotomies than shown here. These may be large and bilateral. Access can be difficult so the best possible exposure is essential. Most surgeons leave any vaginal relaxing incisions unsutured.

Extent of mobilisation. It is essential to mobilise bladder enough to close the defect without tension, but many experienced surgeons repair with only one layer. Thus reducing the amount of mobilisation.

Fat Grafts. Historically the introduction of fat grafts at the Fistula Hospital appeared to increase the success rate, but recently some experienced surgeons have virtually abandoned their use without compromising results. They would not have used fat grafts in the three cases shown on the video. There is no evidence that fat grafts will reduce the incidence of postoperative stress incontinence.

Ureteric catheters. When used for protection of the ureteric orifice they can be removed at the end of the operation unless suturing has been very close to the orifice. Both cases shown in the videos would have been suitable for immediate removal. This simplifies post operative care.

POST OP CARE

Intravenous fluids. If the patient is encouraged to drink plenty pre-op and a good diuresis is noted at operation the drip can be discontinued after the first post operative night, or even earlier.

Bed rest. Most surgeons allow their patients out of bed from the second postoperative day. Prolonged bed rest has its attendant risks and requires a high level of nursing care.

Catheter care. The kidneys dish method is only used in Addis where there is plenty of nursing help. It does require prolonged bed rest that many surgeons would consider inadvisable.

Closed drainage can be used but there is a lot to go wrong unless there is excellent nursing care. Catheters can get kinked and bags over full. Nothing should pull on the catheter. Strapping often comes off.

A better alternative is to allow free drainage into a bucket at the side of the bed. If the catheter is sutured to the patient, strapping is only needed to prevent traction on the suture. When the patient is mobile she can carry the bucket.

High fluid intake is essential throughout the post operative period to reduce infection and minimise the risk of blockage.

There is no need to irrigate the catheters routinely provided the urine output is good.

Ureteric catheters can often be removed at the end of the operation so making nursing easier.

Though some surgeons have advocated less than 2 weeks catheter drainage this is not always successful and 14 days are still recommended.

Antibiotic cover. Many surgeons would only use peri-operative cover.

Many of these modifications are illustrated on the accompanying power point presentation, '*First steps in VVF Surgery*'.