

# 1 INTRODUCTION

Nobody knows how many patients with vesico-vaginal fistulae there are who have been forgotten and are without hope. Estimates are up to 2 000 000 in Africa alone. In Ethiopia, it is estimated that there are 9000 new cases a year. Fistula repair has a reputation for being difficult, but 25% are quite easy and could be repaired by any competent surgeon with a little instruction.

The purpose of this publication is to help the beginner to get started by recognizing the easy cases and to show step by step how they should be repaired. Postoperative care is described and shown to be very simple.

A doctor with good basic surgical skills and some initiative could make a tremendous impact by repairing these simpler cases.

A recent survey of fistula repair throughout Uganda revealed that only 270 repairs were carried out in 2002, the vast majority by visiting fistula experts. Why were so few being done by local surgeons? Reasons given were:

- There was a perceived view that fistula surgery is difficult.
- The results were thought to be poor.
- There was no opportunity to learn fistula surgery.
- There was a lack of special instruments and equipment.
- No specialist nursing care was available.

Some fistula operations are very difficult, and even experts cannot cure every case. The most experienced surgeons claim that 95% of fistulae can be closed (but they have to operate on 10% a second or third time to achieve this figure). However, closure of the fistula does not always mean that the patient will be dry. Another 15% or more will have severe stress incontinence because the urethra and bladder have been so badly damaged. A few may improve, but for those who do not, the operation has failed. Secondary operations for stress are possible, but have uncertain results.

A reasonably experienced surgeon who takes on all the cases that he or she sees can at best probably only make 75% of cases really dry. Of course, the surgeon who turns down the difficult cases will have much better results. For the simple cases described in this account, a near 100% success rate should be possible. This explains the paradox that the better one is at repairing fistulae, the worse are the results, because the expert rarely turns anyone away.

The following points are of note:

- No special instruments or equipment are needed to cure the simple cases.
- Postoperative nursing is important but is not complicated.

I know of no other condition where such a variety exists from the simplest case, which can be completed in half an hour, to the most difficult, which will defeat the most experienced surgeon. The variety of problems encountered is enormous, which is why it takes so long to become an expert. Probably 500 repairs are needed before one can feel really confident.

This account is based on my personal experience of over 600 operations conducted in Uganda (four hospitals), Sierra Leone (three hospitals), and the Addis Ababa Fistula Hospital in Ethiopia. I learnt a lot from a short visit to Dr Kees Waaldijk in Northern Nigeria, who has the largest personal experience in the world (13 000 cases).

Having helped many surgeons perform their first fistula operations, I can see the difficulties they have and understand the advice they need. Many of my operations have been performed in hospitals that have had no prior experience of fistula surgery, but this is no bar to success.

Naturally, fistula surgery is thought to be the province of gynaecologists and should rightly be part of their postgraduate training. In reality, many fistula surgeons have no formal gynaecological training and are simply good general surgeons who teach themselves following basic surgical principles.

One should not be discouraged by the fact of being able to operate on only some patients. A start has to be made somewhere, and one must not try to run before one can walk.

It is hard to imagine any operation that is more satisfying. It transforms the life of a young woman who would otherwise be an outcast.

Many surgeons have tried to tackle or have seen others attempt cases beyond their capability. Such cases usually fail, and everyone becomes discouraged. No surgeon likes failures. This text will show cases that should not be attempted, in order to avoid this embarrassment. Most African countries have hospitals where local experts operate or hospitals that are visited by outside experts. It is important to find out where they are and to refer all but the easy cases to them.

Once a surgeon has done a dozen or so easy fistula repairs, he or she may be encouraged to go further – but it is then important to try to obtain some training from an expert. Of all operations, fistula surgery is an example of one that cannot be learnt from reading a book (except the easy ones to be described here!). It is an art, and progress will be helped by a period of apprenticeship with someone more experienced. Several short visits are better than a single long one, in order to build up experience from one's own cases between visits. One of the problems of learning fistula surgery is that, working in a deep space, only the surgeon can really see what he or she is doing.

Once one understands the basic principles and the three-dimensional aspects of the pathology, to a large extent one has to work it out for oneself. To repair the bad cases, above average manual dexterity is required.