Figures 9–13 show examples of the easier cases that are suitable for a beginner. Figures 14–18, on the other hand, show examples of more complex cases that should not be attempted by beginners.

**Figure 9** This is a medium vesicovaginal fistula at the junction of the urethra and bladder. The margins of the fistula are soft and are clearly seen.

**Figure 10** This illustrates a tiny fistula of the mid-vagina. Urine can be seen leaking when the patient is asked to cough.
Figure 11 This is another simple fistula at the urethro-vesical junction. After a generous episiotomy, this will become much more accessible.

Figure 12 This is just about the easiest case one could hope to find. A metal catheter is in the urethra. The small fistula is just at the level of the urethro-vesical junction.

Figure 13 (a,b) Two more small mid-vaginal fistulae.
Figure 14 (a,b) This is a juxta-cervical fistula that extends high into an open cervical canal. It is a troublesome one to repair, but has an excellent prognosis because the urethro-vesical junction is normal.

Figure 15 The defect in the vagina is so large that the bladder has prolapsed. This is perfectly curable by an expert surgeon.
Figure 16 (a,b) This is a large fistula high in the vagina. When fully exposed after an episiotomy, the ureteric orifice is seen on the edge of the fistula (arrow). This would be quite easy for a regular fistula surgeon, but a novice could get into real difficulties.

Figure 17 This looks like a small accessible fistula, but the vagina is almost completely stenosed beyond the fistula, as indicated by the forceps. Generous lateral incisions in the vaginal wall (indicated by the dashed line) are required to gain access to the fistula, which is otherwise quite an easy one to repair.

Figure 18 This massive defect was closed at the second attempt, but the patient had total urethral incontinence. A large rectal fistula (hidden here) was also present, but was cured (after a temporary colostomy).