

Chapter 7

Discharge

Removing catheters

Urinary catheters are usually removed around 10–14 days post-operatively. A few will need to stay in longer following specific advice by the surgeon.

Patients need to stay for 2–3 days after removal of the catheter to make sure there are no complications before they travel home. Bladder training may be carried out during this time.

A dye test is undertaken before removing the catheter to make sure the fistula is completely healed. This involves 60–100 ml of blue dye solution being pushed into the bladder using a catheter tipped syringe while the suture line is inspected, using a Sims speculum in the vagina, for evidence of the dye emerging.

If no blue dye is seen, the dye test is considered negative and the catheter can be removed.

A positive dye test requires the catheter to be left in place for longer to allow the repair more time to hopefully heal completely. Leaving it in for a further week or two will help further healing of the fistula. The decision on whether to keep the catheter in for a longer duration is guided by how wet the patient has become following surgery. If there is only a small amount of urine leaking on the bed with most still draining through the catheter, it is advisable to leave the catheter in longer as some of these repairs will heal in time.

However, for patients who are wet and most of the urine is leaking on to the bed the chances of closure of the fistula are small. It is advisable to remove the catheter and counsel the patient to return for a further attempt at repair of their fistula in the future.

Assessment for post-repair stress incontinence is carried out during the dye test. After filling the bladder with blue dye and inspecting the suture line, the catheter is removed, leaving the dye in the bladder. If the patient leaks blue dye from the urethra while lying down, this indicates severe stress incontinence, whereas, leaking dye when standing indicates moderate stress incontinence. Stress incontinence should be documented in the patient's notes and followed up appropriately.

It will be distressing for most patients to be discharged with stress incontinence, but they need to be reassured that this can improve with time and pelvic floor exercises. At their 3-month review, stress incontinence will have improved for most women.

Bladder training is carried out after removal of the catheter in many centres but not all. This helps to retrain the bladder to fill up and empty again and gradually increases the bladder volume. Most fistula patients will have had a collapsed bladder due to the continuous leakage of urine.

A simple way is to advise the patient to urinate every hour after their catheter has been removed. Gradually increasing this to every 2 hours, then 3 hours over the next few weeks, to allow the bladder to function normally again, while gradually increasing its volume.

If they are passing urine normally with no urinary retention, they can be allowed to travel home. During the journey, they should be advised to stop every 2 hours if possible, to pass urine if they are travelling a long distance. They should be warned that if they allow the bladder to fill up and become distended during travel, they risk damaging the repair and becoming wet again.

Urinary retention

Chronic urinary retention or 'hypotonic bladder' can be one of the causes of patients being discharged home dry, only to find they are wet within the first 1 or 2 weeks. These patients have often gone home with unrecognised chronic urinary retention. In this circumstance the bladder fills up and does not empty properly, leading to overflow incontinence, so the patient may not realise they are not passing urine properly.

Before discharge home, it is advisable for all patients to test their residual bladder volume after passing urine. This can be done either with ultrasound, if available, or by doing in/out catheterisation straight after the patient voids. It is recommended to check the residual volume three times before the patient goes home.

A residual of over 100 ml is indicative of urinary retention and the patient needs to be reviewed by a doctor. They may need to stay a few days longer to be taught intermittent self-catheterisation to ensure they can empty their bladder properly.

Checking each patient individually before they go home is the responsibility of the nurses. Identifying patients with chronic retention who can then be taught intermittent self-catheterisation will help reduce the chances of patients becoming wet after discharge home.

Stress incontinence

A small number of patients will have had a successful closure of their fistula, but remain incontinent from the urethra (stress incontinence) after surgery. This is disappointing for the patient as they may feel their symptoms are no different. There can be several causes for stress incontinence, the main one being the destruction of the urethral tissue or bladder neck from the birth trauma making it difficult to help get the patient completely dry. The patient may have been left with an exceedingly small bladder after their injury, making it difficult to maintain continence. Bladder retraining is important for all patients. This involves gradually increasing time between voids to slowly increase the bladder capacity.

An experienced fistula surgeon may be able to offer further surgical intervention using skin or muscle flaps, stress sling surgery and bladder augmentation procedures to try and improve the stress incontinence. However, not all patients will benefit from this type of surgery.

Pelvic floor exercises, if done well and consistently, may help some women with stress incontinence and can be taught by the nurses before the patient is discharged home. They should be advised to continue with these exercises for 3–6 months or until their next pregnancy (Appendix C).

Women who have had many attempts at surgery and are still incontinent of urine are often deemed incurable. However, there are a few options to keep them dry and these patients should be advised of these alternative options.

For patients with a very small bladder, a Mainz II pouch operation may be considered if there is a surgeon skilled to perform this operation. This involves diverting the urine from the bladder into a reservoir in the bowel, so the patient will pass urine from their bowel and no longer pass urine from the urethra. However, this operation potentially reduces the life expectancy of the woman, hence good counselling and clear explanations are required before the patient agrees to the surgery.

Patients left with a very small bladder can also benefit from bladder augmentation. This involves using part of the patient's bowel (ileum) to increase the size and capacity of the bladder. These patients will have to empty their bladder using clean intermittent self-catheterisation, as the bowel segment of their bladder will not expand and contract the way a normal bladder does. Blockages can also occur from bowel secretions from the part of the bowel that has been used. These patients need a well-functioning urethra for this operation to be a success.

Discharge advice for fistula patients

All patients who have had fistula surgery are advised to abstain from sexual activity for 3–5 months following discharge home, and recommended to use contraception to delay future pregnancy for up to a year if possible.

They are also advised not to do any heavy lifting for at least 3 months after going home. For some this may be difficult if they are subsistence farmers, but it should be stressed that they could become wet again if they do not follow the advice.

If there are any signs of infection, either urinary or discharge from the vagina, the patient should seek medical help as they may require treatment with antibiotics.

Any future pregnancies will require safe delivery by caesarean section. This should be stressed strongly to the woman and family, as her chances of developing another fistula from subsequent vaginal delivery are high. If she becomes wet again, she is advised to contact the fistula repair centre and attend for review.

Discharge advice after repair of 3rd and 4th degree tears

Most patients will be able to return home 2–3 days after an anal sphincter repair. If their bowels are moving and the wound is clean and dry, they can be discharged home with antibiotics and a stool softener such as bisacodyl 5 mg for 10 days and advised to continue drinking plenty of fluid.

Patients need to continue cleaning the wound after every bowel motion to prevent the wound becoming infected and breaking down. Sitz baths are not encouraged unless the wound is infected. Cleaning with water and drying the skin after emptying the bowel will suffice. If

they experience discharge from the wound, they should wear a small pad to keep the wound as clean as possible.

Sexual activity is not advised for the first 3–5 months, as early resumption of sexual intercourse can cause the repair to break down and for the patient to become incontinent of faeces again. Patients should be advised that although the skin has started to heal on the outside, it takes longer for complete healing of their wound.

A high fibre diet to make sure they are passing soft stool is advised. Drinking plenty of fluid also helps to avoid constipation. If a patient becomes constipated the large, hard stool and straining to pass faeces will put pressure on the wound, which can lead to a breakdown of the repair.

For a woman who has undergone repair of a 4th degree tear, all future deliveries should be by elective caesarean section and her family advised to plan for this. They need to understand that if the woman has another vaginal delivery, the likelihood of a 4th degree tear is high and subsequent repairs do not have the same success rate. However, if the woman does end up labouring and is unable to reach a hospital quickly enough for a caesarean, she should be advised to push gently during the birth, with her perineum supported by a midwife, to ensure a slow, controlled delivery and reduce the risk of a repeat 3rd or 4th degree tear. Patients with a previous 3rd degree tear repair on the other hand may have a vaginal delivery under the supervision of suitably trained medical personnel.

Follow up

In some centres patients will be asked to attend for follow up with the doctor a few months after being discharged home to check they have not developed further problems or complications after surgery. The nurse in charge of the ward should also keep a register with the patients' names and contact details. Mobile phones are a good way of keeping in touch with patients if they have travelled a long distance to access surgery. Also, giving them a phone number to call at the fistula treatment centre, if they run into problems once home, is helpful.

Patients who attend hospital with a fistula when there is no surgery available at that time should have their name and contact details added to a register and should be recalled when surgery becomes available. It is important to never close the door on a woman with a fistula, bearing in mind the trauma she has already suffered and the difficulty she may have had in presenting to the hospital for treatment.