Chapter 8

Discharge

Removing catheters

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

Patients should stay in hospital for 2–3 days after removal of the catheter, to make sure there are no complications before they travel home.

Bladder training is carried out after removal of the catheter. 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 bladder that has not functioned normally for some years due to the continuous leakage of urine, so the bladder can take time to work properly again.

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 days.

All patients should have residual volume assessed on the day when the catheter is removed. This involves asking the patient to void in a bucket and measuring the voided volume. An in/out catheter should then be placed and any residual volume in the bladder measured.

If the residual volume is greater than 100 ml or more than the voided volume, the patient has urinary retention. In this case, the patient should have residual volumes checked over the next few days before discharge home.

If urinary retention persists, the patient should be taught intermittent self-catheterisation before discharge home if she is to remain dry.

If the patient is passing urine normally with no urinary retention, she can be allowed to travel home. During the journey, the patient should be advised to stop every 2 hours, if possible, to pass urine if she is travelling a long distance. If it is not possible to stop to urinate, patients should be

encouraged to pass urine in the clothing they presented to hospital in when they were wet. 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.

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

For any patients who are wet before the catheter is removed, the chances of closure of the fistula are small at this point. It is therefore advisable to remove the urinary catheter and to ask the patient to return for review and, potentially, for additional surgery in the future.

Dye tests

Dye testing is generally done during screening, to check the presence and location of a fistula. The procedure may also be done in theatre before a fistula repair takes place. In addition, some centres do dye tests prior to discharging the patient. Great care should be taken when doing a dye test in the early post-repair period, not to damage or traumatise the newly repaired fistula, for example, through improper use of the Sims speculum or by overfilling the bladder with the dye solution.

It is, therefore, better if the surgeons do the dye tests. They are likely to be experienced at doing them and can subsequently advise on appropriate care and management of each patient.

Pad tests

Pad tests are an easy way of finding out if a patient is wet after removal of the urinary catheter or can be used during screening to confirm if a patient has urinary leakage.

To do a pad test, the dry pad is first weighed, and the patient is asked to drink 500 ml of water. She is then requested to wear the pad inside her underpants, to walk around for an hour, to do five squats and five jumps and to walk up some steps. After an hour, the pad is weighed again and the difference in the weight of the pad before and after the test will determine the extent of any urine leakage.

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 urinary diversion operations.

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 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.