

3 MANAGEMENT OF EARLY CASES

Conservative Management

After a caesarean section for prolonged obstructed labour, the catheter should be retained for at least ten days. Earlier removal predisposes the patient to chronic retention. The bladder is often atonic after a prolonged labour. If there is urinary leakage after removal of the catheter, it should be reinserted immediately.

Initially, a defect will probably not be visible, because it will be out of sight in the cervix region or because of sloughing necrotic tissue. The patient should be kept on continuous drainage, providing most of the urine is coming through the catheter. After two or three weeks, it should be possible to assess the size of the defect by palpation and inspection. 20–40% of small defects (<2cm) may still heal with another two to three weeks of bladder drainage. Larger defects and those attached to the pelvic side wall are unlikely to heal with drainage. Indeed, the balloon of the foley catheter is often found in or through a larger fistula, actually keeping it open. Always check the placement and position of the catheter to ensure this hasn't happened as it will keep the fistula open and might make it worse!

After vaginal delivery, a leak of urine may indicate anything from a tiny hole to massive necrosis. The patient should be examined gently with a Sims speculum. If slough is seen, it can be gently pulled out if loose. (Figure 3.1) This should be followed by regular irrigation of the vagina. Palpation and inspection with a Sims speculum will help to judge the size of the fistula. If it is less than 2cm in diameter, the catheter should be kept in at least another four weeks. With larger fistulae it is difficult to keep the catheter in the bladder. Always check by vaginal examination that the catheter has not gone through the fistula into the vagina.

Fistulae that have not healed spontaneously with four weeks of drainage are unlikely to do so.

Note: Antibiotics have no part to play in the healing of fistulae. The cause is ischaemic necrosis, not infection.

Prevention at Caesarean Section

In some countries where fistulae occur, two thirds of patients have had their obstructed labour relieved by caesarean section—but clearly too late. The remaining one third have eventually delivered vaginally. Incidence of caesarean section is different in other countries. In Ethiopia, only 15% of fistula patients have had a caesarean section, because most people live in remote areas far from hospitals, although this picture is now changing and the statistic quoted here was from 2010. In Tanzania 85% of fistula patients have had a caesarean.

The ischaemic damage may have occurred already by the time of the caesarean section, but the doctor can take steps to minimise further damage. The lower segment will be very stretched and oedematous. Remember that the bladder should be dissected well down off the lower segment. The incision in the lower segment should be on the high side and the lateral ends curved upwards to minimise inaccessible tears and tearing into the lateral vessels. (The left ureter is most at risk when repairing a lower segment, especially if the incision into the lower segment has torn laterally and if the bladder and the ureter have not been reflected inferiorly).

When the baby's head is deeply impacted in the pelvis, it is better to get help to push up the head vaginally than to force a hand down between the head and the lower segment. Forcing your hand may produce large lateral tears and also increase the damage already done to the bladder in the midline. It is best to have someone push the baby up from the vagina and the operators' hand should reach carefully down to disimpact the baby's head. Don't flex your hand when bringing the baby's head out of the pelvis, pull superiorly until you can easily get it through the lower segment incision. Flexing your hand will just push your hand against the inferior lower segment, tearing it more. The alternative is to extract the baby as a breech birth if possible. To do this, reach for the breech superiorly and deliver that through your lower segment incision first.

Tears in the lower segment can be difficult to suture, and sometimes fistulae are produced when the doctor inadvertently picks up the bladder. This produces an intra-cervical fistula that can be quite a challenge to close and is not for a beginner. In trying to repair the angles of these tears ureters are at risk.

Are too many caesarean sections being performed for dead babies? In Uganda, 88% of mothers who develop fistulae after a caesarean section have a stillbirth. In the 12% with live babies, there is a strong suspicion of iatrogenic injury to the ureter or bladder.

A generation ago, it was commonplace to recommend a craniotomy for a dead baby stuck in the pelvis, but this seems to have been abandoned. It is not practised in teaching hospitals; perhaps it is too difficult for many young doctors to develop the skill. A craniotomy performed badly may do more harm than good. Is it time to look again at this procedure? This is something that only obstetricians working in the fistula affected countries can answer.

Early Repair

Naturally, the sooner a patient can be cured the better. The longer she is incontinent, the greater the chance she will be abandoned. This is almost inevitable when she perceives that there is no chance of cure.

Most surgeons advise waiting at least three months from the injury before operating. In the early months, the surrounding tissues are oedematous and hyperaemic, making them friable and difficult to handle. By three months, they should be sufficiently mature.

In spite of this, some surgeons have been very successful in closing *selected* fistulae before three months and have strongly recommended this approach. Excellent results have been published, but the method has not yet been well illustrated. An operation can be attempted as soon as the

slough has come away and the tissues are clean. One experienced doctor will remove the slough and repair a small fistula at the same sitting. It is technically more difficult to operate when the tissues are recovering. The tissue forceps may tear the soft oedematous vagina and bladder and the sutures cut through.

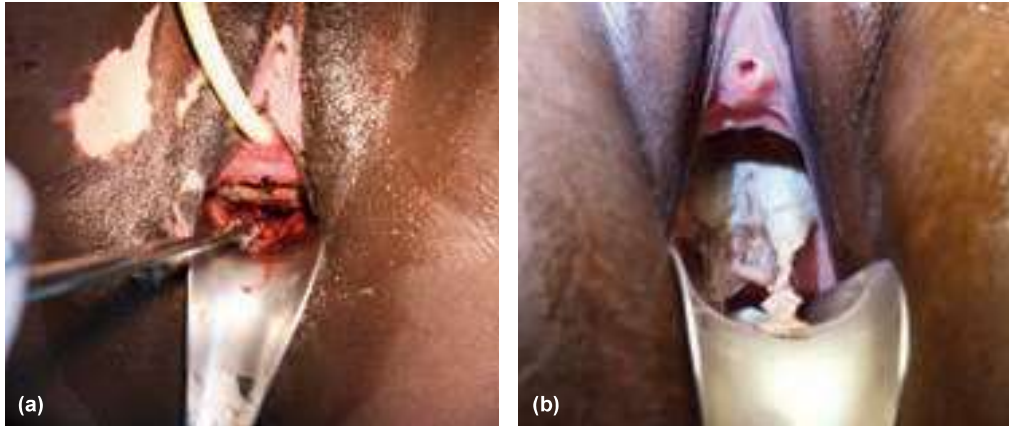


Figure 3.1

a) Slough should be removed only if it is really loose. This is not ready. b) This slough is loose and easily debrided.

I have adopted a flexible approach in which each case is judged on its merits. Some fistulae are perfectly clean and healthy at two months, and can be repaired safely (Figure 3.2); on the other hand, some are distinctly friable even at three months. It is the appearance of the fistula that matters more than its age. If in doubt, wait.



Figure 3.2

This fistula is only two months old, but it is clean, doesn't bleed on touching and is ready to repair.

We recommend that a beginner follow traditional advice and delay repair for three months. The first repair always has the best chance of success, and this should not be compromised. Exceptions can be made to this rule after some experience has been gained.

Further Reading

Waldijk K. The immediate management of fresh obstetric fistulas. *Am J Obstet Gynecol* 2004; **191**: 795–9.