

3 MANAGEMENT OF EARLY CASES

Conservative management

After a caesarean section for prolonged obstructed labour, the catheter should be retained for at least 10 days. Earlier removal predisposes 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 region of the cervix and because of slough. The patient should be kept on continuous drainage, provided that most of the urine is coming through the catheter. After 2 or 3 weeks, it should be possible to assess the size of the defect by palpation and inspection. Up to 20–40% of small defects (<2 cm) may still heal with another 2–3 weeks of bladder drainage.

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. Slough should be seen; it must not be pulled or cut. Only if it is loose can it be gently pulled out (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 2 cm in diameter, the catheter should be kept in at least another 4 weeks. It is difficult to keep the catheter in the bladder in the case of a larger fistula. Always check by vaginal examination that the catheter has not gone through the fistula into the vagina.

Fistulae that have not healed spontaneously with 4 weeks of drainage are unlikely to do so.



Figure 3.1 Slough should be removed only if really loose. This is not ready.

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

Prevention at caesarean section

In Uganda, two-thirds of patients with fistulae have had their obstructed labour relieved by caesarean section – but clearly too late. The remaining one-third have eventually delivered vaginally. In other countries, the incidence of caesarean section may be different. In Ethiopia, only 15% of fistula patients have had a caesarean section, because most people live in remote areas far from any hospital.

The ischaemic damage may already have occurred by the time of the caesarean section, but the doctor can take steps to minimize any further damage. The lower segment will be very stretched and unhealthy. 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 minimize inaccessible tears (the left ureter is most at risk when repairing a lower segment).

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. This may produce vertical tears and increase the damage already done. The alternative is to extract the baby as a breech birth if possible.

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 the beginner. Ureters are at risk in difficult operations.

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 developing world can answer.

Early repair

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



Figure 3.2 This fistula is only 2 months old, but is clean and suitable for repair.

Most surgeons advise waiting at least 3 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 3 months, they should be sufficiently mature.

In spite of this, some surgeons have been very successful in closing selected fistulae before 3 months and have strongly recommended this approach.¹ Excellent results have been published, but the method has not yet been well illustrated or widely understood. We have not yet been able to reproduce such good results.

We have adopted a flexible approach in which each case is judged on its merits. Some fistulae are perfectly clean and healthy at 2 months, and can be safely repaired (Figure 3.2); on the other hand, some are distinctly friable even at 3 months. It is the appearance of the fistula that matters more than its age. If in doubt, wait.

We recommend that a beginner follow traditional advice and delay repair for 3 months. The first repair always has the best chance of success, and this should not be compromised. After some experience has been gained, exceptions can be made to this rule.

Reference

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