Evaluation and Treatment of Vesicovaginal and Rectovaginal Fistulas in Lower Resource Settings:

*Abdominal approach to vesicovaginal fistula repair*

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Disclosures

• I have no disclosures
Increasing number of vesico-uterine and vesico-cervical fistula

- Often have portion (usually anterior lip) of cervix missing
- Upper cervical or lower uterine involvement
Why an abdominal approach?

• Ureteral involvement
  – Need for reimplantation
• Lesion accessibility and mobility
  – Degree of scarring
• Small bladder capacity and need for augmentation
• Vesicouterine fistula with need for hysterectomy
Hysterectomy consent

• Be familiar with consent guidelines and local regulations
• Be sure patient understands consequence of uterine removal
Preoperative considerations

- Considerations for abdominal surgery
  - Anesthesia
  - Antibiotics
  - DVT prophylaxis
  - Instrument availability
    - Cautery and suction
    - retraction
  - Blood products
  - Nursing/circulator support
    - counts
Operative approach

- Low lithotomy
  - Vaginal access if needed
  - Easy urethral access
- Midline vs Pfannensteil incision
  - Usually use prior incision
  - Midline may give better access for omental interposition
- Intraperitoneal or extraperitoneal approach
- Extraperitoneal approach
  - Fistulous tract excised through anterior cystotomy
  - Limited exposure
  - Useful if very limited peri- and post-operative resources
• Continuous identification of ureters
  – During hysterectomy and after
• Stents
  – Preoperative
  – Retrograde intraoperative
  – Can be placed only for op or for postop as well
• Postoperative visualization
  – Proximity of ureters to fistula repair
  – If no stents
Finding the fistula

- Meticulous dissection to fistula vs vertical cystotomy to fistula
- Attention to planes and anatomy
  - Easy to get disoriented
  - Vaginal probe helpful
  - Continuous “regrouping”
- Adequate lateral dissection
  - Avoid operating in a hole
  - Adequate mobilization of tissue around fistula
    - Need to assess tissue quality
Basics of closure

- Mucosa and fibromuscular layer of bladder closed
- Vaginal opening closed
- Preferably non-opposing suture lines
Be sure you are done

- Don’t assume one fistula
- Adequate backfill
Interposition

- Creates barrier between bladder and vagina
- Omentum
  - May need to create J-flap with mobilization at the right gastroepiploic pedicle
  - Pully stitch helpful if low in pelvis
- Pericolic or mesenteric fat
- Lateral pelvic peritoneum
Postoperative considerations

• Ability to follow-up complications
  – Wound infection
  – Ileus
  – DVT/Pulmonary emboli
  – Bleeding
  – Bowel injury

• Timing of surgery