No Disclosures
Rational for Postoperative Care

• Intraoperative injury may be managed by:
  • Identification
  • Closure
  • Continuous post-operative bladder drainage

• Continuous drainage
  • Decreases tension on suture lines
  • Decompressed bladder more likely to re-urothelialize/heal
FRIEND

- Mnemonic for fistula formation:
  - F Foreign body
  - R Radiation
  - I Infection
  - E Epithelialization
  - N Neoplasm
  - D Distal obstruction
Catheter Care

• Foley catheter, suprapubic catheter, or both.
• Lack of data to guide postoperative catheter management
• Continuous bladder drainage recommended from 1 to 14 days.
• The duration and type of catheter should be determined by the surgeon based on experience, preference, and complexity of the repair.
Catheter Removal

• Cystogram prior to catheter removal
  • Evaluate success of fistula closure
  • If unsuccessful, prolonged catheterization may allow continued healing.
Antibiotics

• Minimal data exist on the use of antibiotics
  • after either rectovaginal or vesicovaginal fistula repair
  • Some surgeons use therapeutic or prophylactic antibiotics for genitourinary fistulae with an indwelling catheter
  • Cochrane review on prophylactic antibiotics with postoperative catheter use up to 18 days reported limited evidence supporting prophylactic antibiotic use for the first 3 days after surgery or until catheter removal
  • The authors of that review suggest interpreting those results with caution because the benefits of decreased bacteriuria or urinary tract infection sx may not warrant the risks of prophylactic abx.

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Antibiotics Continued

• Postoperative antibiotics, although commonly used, have not been studied after rectovaginal fistula repair, although women undergoing rectovaginal fistula repair are at increased risk for postoperative infection.

• Perioperative antibiotics improve success rates of acute anal sphincter laceration repair.

• These data support the use of antibiotics at the time of fistula repair.

• Traditionally, after rectovaginal fistula repair or sphincteroplasty, women were placed on a low-residue diet to delay their first bowel movement. Unfortunately, this results in severe constipation and straining, which, in some cases, led to repair failure. Recent colorectal literature supports placing women on a regular diet after colorectal repairs; these data are supportive of a regular diet after rectovaginal fistula repair.
Diet

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Colostomy

• A diverting colostomy may be used as part of a rectovaginal fistula repair but typically is performed only for repeat procedures. Data to guide performance of a diverting colostomy or loop ileostomy are lacking and left to the discretion of the surgeon.

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Urinary Continence

• Fistula repair does not guarantee continence
• Postoperative urinary urgency and frequency are common during and immediately after catheter use
  • Anticholinergic medications may be useful in this setting
• Stress urinary incontinence has been reported in 10-12% of patients after genitourinary fistula repair
  • Concomitant anti-incontinence surgery such as an autologous pubovaginal sling is controversial.
• Decreased bladder capacity may not allow patients to adequately store urine despite fistula closure.
Anal Continence

• Successful closure of a rectovaginal fistula does not guarantee bowel continence

• Fistula repair in the setting of a disrupted or damaged anal sphincter may result in fecal urgency or decreased sensation of rectal filling
  • Resulting in continued loss of fecal material per rectum rather than per vagina
  • Concurrent repair of a disrupted sphincter at the time of rectovaginal fistula repair may decrease the incidence of persistent fecal incontinence sx, although little literature supports this practice.

• Women should be followed after repair and offered physiotherapy, with or without biofeedback, dietary manipulation, and use of constipating medications such as loperamide for improved bowel continence.
Preoperative Expectations

- It is important to discuss postoperative expectations
  - Success rates of the fistula repair
  - Emphasize that closure of the fistula tract does not ensure continence
  - Continuous bladder drainage is indicated after most genitourinary fistula repairs
Sexual Function

- Sexual activity and function should be determined before initiating fistula treatment
  - Presence or absence of dyspareunia before fistula formation
- Recommend abstaining from sexual intercourse for 6-12 weeks after repair
- Postoperative sexual fnn was evaluated in 99 women 6 months after vaginal or abdominal surgical repair of genitourinary fistulae
- Female Sexual Function Index
  - Validated questionnaire assessing domains of desire, arousal, lubrication, orgasm, satisfaction, and pain
- Significant improvement in sexual function after Latzko transvaginal or trasabdominal repair
  - No statistically significant differences in FSFI scores.
- A separate study evaluated sexual fnn in patients who had a Martius flap
  - FSFI with a mean f/u of 85 months (range 6-202 months).
  - In the FSFI, higher scores indicate better sexual fnn with a max score of 36.
  - There were no differences seen between groups with an average FSFI score of 28.
Thank You