

Post Repeat Lower Segment Caesarean Section Cervicovesical Fistula

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Abstract: A 35 year old female patient G2P1L1 with previous LSCS with 9 months amenorrhea with labor pains was admitted and caesarean section was done for cephalo – pelvic disproportion with foetal distress. Patient developed cervico-vesical fistula which was successfully repaired by total abdominal hysterectomy and fistula was repaired using peritoneal flap .

Introduction

Incidence of vesico-vaginal fistula is 0.5-03% [1] . In developing countries , obstetric fistulae occur in 80-90% mainly due to obstructed labor. Whereas in developed countries iatrogenic causes and surgical injuries are more common [2]. 87% of fistulae are found in post caesarean or hysterectomy patients. Bladder injury is twice more common in repeat caesarean sections.

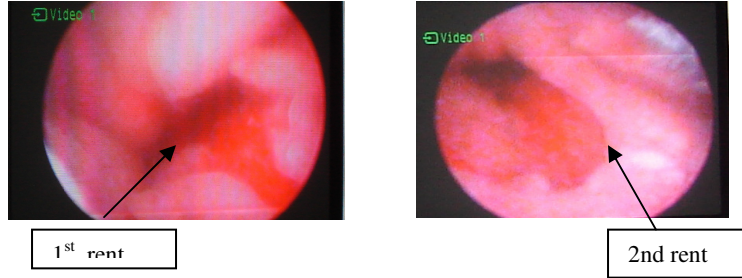
Case History

A 35 year old female patient gravida 2 para 1 living 1 (G2P1L1) with previous lower segment caesarean section (LSCS) with history of 9 months of amenorrhea reported to our hospital with labor pains since 6 hours with no history of per vagina (P/V) bleeding or leaking. Previous caesarean section was done for obstructed labor (done in the same hospital) as per previous records. Her menstrual history was regular & last menstrual period was not known and no other significant history was noted. On examination she was found to be short stature, moderately built and pale lady with stable vital parameters. Systemic examination was found to be normal. On per abdominal examination uterus 38 wks size, contracting 2-3 times in every 15- 20 min and contraction lasting for 10-15 sec. Head was 4/5th palpable. There was no scar tenderness and fetal heart sounds (FHS) were found to be regular with 130 beats per minute. Estimated fetal weight (EFW) was 3250 gm. Per vaginum findings revealed 4-5cm dilated cervix, 70% effaced, membranes were absent and caput was present , liquor was thin meconium stained, vertex at -3 station. Major cephalopelvic disproportion was present. Preoperative investigations were found to be within normal limits, urine was clear.

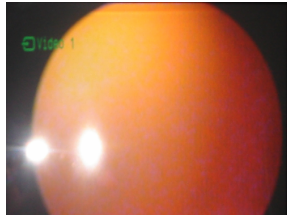
Patient was prepared for emergency repeat LSCS. Abdomen was opened in layers. Live baby was extracted through the incision made just above the previous LSCS scar. Previous LSCS scar was intact & bladder was adherent to the scar. No intra operative complications were noted. Post operatively haematuria was noted and patient complained of bed wetting. Per speculum examination revealed urine leak high up in vagina. Urinary bladder was catheterized for 21 days, bed wetting persisted intermittently. Three swab methylene blue test observation was colourless

soakage of upper most swab. Hysteroscopy and cystoscopy revealed Two rents about 1.5 x 1.5cm and 0.5 x 0.5 cm seen in supra trigonal region, communicating cervical canal. Patient was explained about the complications and after 8 wks with the help of urologist total abdominal hysterectomy and bladder repair using peritoneal flap was done. Post operative period was uneventful, no urinary leakage, ureteric catheter was removed on 10th post operative day and patient was discharged. Transurethral catheter & Urosac bag was removed after three weeks.

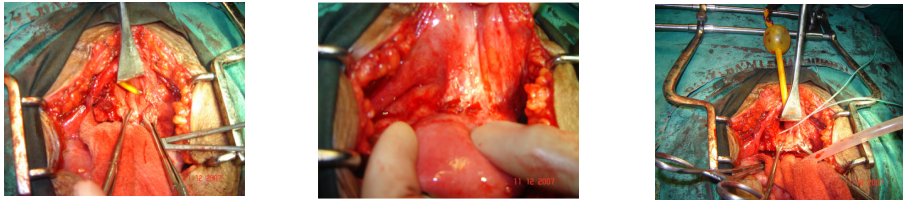
CYSTOSCOPIC VIEW



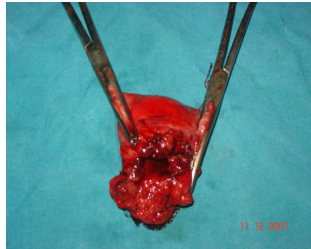
FOLEYS CATHETER BULB IN BLADDER SEEN THROUGH HYSTEROSCOPE



LAPAROTOMY



Hysterectomy Specimen



Discussion

Most commonly urinary fistulae occur following gynaecological surgeries [3]. Improved obstetric practice has reduced the incidence of vesico vaginal fistulae. Almost all are associated with necrosis of bladder wall because of obstructed labor. It may be due to dehiscence of previous LSCS scar. Inadequate mobilization of bladder laterally and inferiorly, bladder may be injured during the delivery of large fetal head. Bladder wall may be accidentally included in the sutures used to close the uterine incision. When the sutures are absorbed and fistula forms, patient may develop cyclic haematuria (menouria) [4]. For diagnosis clinical examination cystoscopy, cystogram and hysteroscopy are useful.

Although small fistulae close spontaneously (5%) [5] or with cystoscopic fulguration but most often surgery is required. The repair is either by transvaginal, transabdominal or transvesical approach [6]. In this case transabdominal approach was chosen, as it was a complicated fistula. There were two fistulae with fibrosis and total involvement of anterior lip of cervix. Repair was not possible without hysterectomy. Thus total abdominal hysterectomy with fistula repair using peritoneal flap was done. The cure rate following repair of bladder fistulae vary from 70% to 96% [7].

Most bladder fistulae are preventable with good obstetric attention and care during surgery. Gynaecological surgeries leading to urological injuries occur commonly which lead to serious implications with morbidity and medicolegal problems [8]. Gynaecologists should be alert to detect, treat and take preventive steps to avoid such complications.

If an injury to bladder is recognized and repaired during surgery itself, fistulae are unlikely to occur [9]. If injury to the urinary tract is not recognized and not repaired during surgery it may lead to malpractice suits against gynaecologist.

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