CASE REPORT

A rare case of irreparable vesico-vaginal fistula of 45 years duration successfully managed by urinary diversion

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ABSTRACT

In developing countries most of the fistulas occur as a catastrophic complication of obstructed labor in young women. Constant dribbling, wetness, and stink lead to social outcasting of patients of vesico-vaginal fistula (VVF) making their life miserable. In most of the cases, timely surgery taking all required precautions is successful. In small number of cases, fistula is irreparable. Under such circumstances urinary diversion helps. Very few cases are reported in literature, where patients have endured fistula for more than 40 years. A case report of a patient of VVF, who suffered for 45 years without seeking any treatment because of prevailing circumstances is presented here. The fistula was irreparable. Urinary diversion was the only option available. She was successfully managed by urinary diversion with an ileal conduit. Now patient is leading a contented life.

Key Words: Irreparable, ileal conduit, obstetric fistula, obstructed labor, ureteric transplant

INTRODUCTION

Vesico-vaginal fistula is a complication of obstructed labor.[1] Continuous dribbling of urine and offensiveness results in social outcast.[2] This leads to immense emotional trauma and makes life of the patient miserable. Early treatment is helpful to these patients. Most of the times the standard fistula surgery following 3-6 months of delivery gives good results. In some cases the fistula may be large and tissue destruction may be so extensive that repair is impossible and in such irreparable cases, some form of urinary diversion is advised. Very few cases are reported in literature, where patients have endured fistula for more than 40 years before seeking surgical help. Presenting a case of irreparable fistula, in a 65-year old patient managed successfully by urinary diversion.

CASE REPORT

Mrs. S, a 65-year-old lady from a small village, with low socioeconomic background, presented in gynecology department of a tertiary care hospital, with continuous dribbling of urine since 45 years. Her obstetric history revealed that she was married at the age of 14 years, and was six para with only one live issue. Her initial four deliveries were home deliveries which were prolonged and each of them ended up in the delivery of stillborn child. Fifth was a live born preterm child. Sixth time again she had prolonged labor and she delivered a stillborn baby. She started dribbling of urine from the same day. Soon after her last childbirth her husband died. Poverty, lack of home help and nonavailability of medical help in the village compelled her to suffer from incontinence and live a miserable life. After 45 years, when her grand son started earning and shifted to the city, she decided to take medical help. As she was desperate to get treated and wanted to spend at least last few years of her life in dry state, she was brought to our hospital

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as she was refused surgery at government hospitals.

She was a thin built, old lady weighing 40 kg with height of 140 cm. Her general and systemic examination revealed no abnormality. On local examination, surprisingly, vulval excoriation was minimal (which she explained was possible because of the special sand pads which she used to stitch at home, where sand worked as absorbent). Per speculum examination was not possible because vagina was stenosed and could hardly admit one finger. On per vaginal examination, a large rent could be felt through anterior vaginal wall. Proximal urethra, bladder neck and trigone were destroyed and anterior lip of cervix was absent. Small posterior lip of cervix could be felt. Uterus was small in size. Fistula margins were thick, fibrosed, and it was fixed to pubic bone.

Her kidney function tests and IVP were normal. Cystoscopy revealed both ureteric openings close to fistula edges. Bladder wall was small, extremely contracted, and fibrosed.

Fistula repair was obviously impossible. The case was discussed with urosurgeon of the hospital. Option of ileal conduit as urinary diversion was given and counseling was done accordingly. Surgery was done and the ureters were anastomosed to the newly formed ileal conduit. The open end of ileal loop was brought out and fixed in right ileac region. Urine bag was fitted. Postoperative period was uneventful and she was discharged on 10th day. Care of ileal opening and changing of the bag was taught to her and first replacement was done under supervision in the hospital. Now 4 years past the surgery, patient comes for regular follow up. Her last visit was 1 month back. She cannot afford to use collecting devices available in market and is using simple plastic bags. She is totally dry and leading a very contented life.

DISCUSSION

Very few cases are reported in literature, where patients have endured fistula for more than 40 years before seeking surgical help. Moirs in 1967 and Russel in 1967 have reported cases repaired after 44 years and 47 years respectively after fistula occurrence.[3] Miklos[4] has reported a case of VVF of 47 years duration. It was simple small fistula, treated successfully, vaginally. Our patient reported after 45 years with irreparable fistula.

In majority of cases, the irreparability is caused by multiple factors like failed previous repairs, damaged urethra, a small bladder with loss of bladder tissue and severe fibrosis. For such patients there are only two options: Do nothing or perform some form of urinary diversions.[5] The various diversion procedures available are as follows:

- The continent ileal bladder – This is a major 5-6 h operation requiring a high degree of skill. It is complex and associated with high degree of morbidity.[5]
- Diversion of urine into the large intestine can make the patient dry by day and often at night, but at the price of significant morbidity and risk to life expectancy.
- Low pressure colonic pouch MAINZE II surgery for urinary diversion is associated with acidosis, night-time incontinence and infection.[6]
- Mitrofanoff procedure – Here, ureters are diverted into a pouch made of isolated caecum and ascending colon. Appendix is reversed and implanted into pouch and is brought out in right iliac fossa or through umbilicus. The patient empties pouch by self-catheterization. There is significant incidence of problems of stenosis and difficult catheterization.[7]
- Uretero sigmoidostomy – Urinary diversion by Uretero sigmoidostomy is associated with the long-term consequences such as ureteral stenosis and hydronephrosis, acute and chronic pylonephritis, electrolyte imbalances, and diarrhea.[8]
- The ileal conduit – The ileal conduit is a simple procedure where diversion can be performed with low morbidity and good satisfactory results but there is a need of external collecting device in this procedure.[8]

Considering the patient's age, general condition, and other factors, decision of ileal conduit as urinary diversion was taken in our patient rather than other diversion procedures. The procedure was successful and patient is satisfied.

This case indicates that age is no bar to this kind of surgery because ultimately, it is the quality of life that matters. Even after 45 years of duration of fistula, if patient seeks treatment, it should not be refused, irrespective of the fistula being simple or irreparable.

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