Abstract:
Presenting an interesting case of neglected proximal urethrovaginal fistula following an obstetric trauma, which was repaired transvaginally.

Keyword:
Urethrovaginal fistula, Obstetric trauma

A 49-year-old lady, a widow presented to our outpatient department with complaints of continuous dribbling of urine for the past 22 years. There is no history of normal voiding between the urinary leak. There were no other urinary complaints.

22 years back she had undergone an emergency caesarean section elsewhere for obstructed labour, due to uncontrolled intra partum bleeding hysterectomy was done. No records were available. On post-operative day 5 upon removal of the catheter there was a continuous urinary leak per vaginum. The leak persisted and she was discharged on the 10th post operative day with the assurance that the leak would subside in due course of time. Patient has not sought any professional help for the past 22 years due to ignorance about the availability of reconstructive procedures for her condition.

Examination:
She was short statured.
Examination of the abdomen was normal, scar of the previous surgery was healthy. Local examination revealed a continuous pooling of urine in the vagina, induration was felt 3 cm proximal to the urethral meatus in the anterior vaginal wall, signs of ammoniacal dermatitis of the surrounding areas were seen.

Hemogram and renal parameters were normal. Urine analysis and culture could not be done due to inability to collect the specimen. USG KUB revealed normal upper tract, bladder was empty. Xray KUB was normal. Intravenous urogram revealed normal uptake and excretion of contrast from both the kidneys, with reduced bladder capacity and extravasation of contrast into vagina was seen.

Cystoscopy - Revealed a fistulous communication between the urethra and vagina situated just below the bladder neck, measuring around 1x 1cm.
Operative procedure: Patient was positioned in lithotomy and a foley catheter was introduced into the fistula and bulb inflated to facilitate dissection, simultaneous mobilisation of the vaginal and urethral walls done and vaginal flap was raised. The urethra was closed transversely and the vaginal closed vertically. Intraoperative and postoperative period was uneventful, foley's catheter was removed after 2 weeks. Patient voided well, and was free of leak.

Discussion:
Clinical presentation: 90% of obstetric and iatrogenic injury usually present within the first week. Fistulas following radiation therapy may present late. The clinical presentation depends on the location and size of the fistula. Patient may be continent and minimally symptomatic in distal fistulas and leak might be seen during or after void. In a case of proximal urethral fistula, continuous leak or intermittent, positional leak may be seen. Other symptoms include recurrent UTI, and Ammoniacal dermatitis.
Preoperative evaluation includes physical examination to rule out stress and urge incontinence and pelvic organ prolapse. Urine analysis, IVU, USG KUB and Urethrocystoscopy.
Ideal to repair the fistula after 2 months following the insult. Most of the fistulas are repaired by vaginal route, extensive excision of perifistulous tissue should be avoided. During suture placement urethral mucosa should be avoided. Urethra should be closed in 2 layers to avoid recurrence. Interpositional tissues (Maurtius flap) should be considered when the closure lines and vaginal tissues are of questionable quality.

References:


