Prevention and Recognition of Obstetric Fistula Training Package

Module 7:
Identification of Obstetric Fistula

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Identification of obstetric fistula

- The objective of this training is to provide knowledge and skills ONLY for the initial identification and assessment of women who may have obstetric fistula; not definitive diagnosis which requires more careful examination and highly skilled providers
- Fistulas are described according to the anatomic location (depending on the progress/descent of fetal head during labor)
  - Vesico-vaginal (between bladder and vagina)
  - Utero-vaginal (between uterus and vagina)
  - Vesico-uterine (between bladder and uterus)
  - Uretero-vaginal (between ureters and vagina)
  - Recto-vaginal (between rectum and vagina)

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Classification systems for obstetric fistula

- There are various different classification systems surgeons have designed to assist with planning for and documenting surgical repair. Most include:
  - Size: large or >3 cm involves most of anterior vaginal wall and more difficult to repair
  - Amount of scarring: fistulas with extensive scarring are more difficult to repair
  - Whether or not the fistula is circumferential
  - Distance between fistula and the external urethral orifice (EUO or “opening” of the urethra): if this distance is > 5cm it usually does NOT involve the neck of the bladder and is simpler to repair
  - Estimation of bladder size

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Vesico-vaginal fistula (VVF)

- Between bladder and vagina
- The most common type of obstetric fistula
- Women with a fistula involving the bladder will have leak urine continuously or almost continuously

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Recto-vaginal fistula (RVF)

- Between vagina and rectum
- Not as common as VVF and unusual to have ONLY a RVF
- These women will develop bowel incontinence (leakage of stool) and/or flatulence
- More commonly associated with a traumatic injury during childbirth; may be associated with:
  - Forceps delivery or
  - Poor repair of an episiotomy or perineal laceration.

Location of obstetric fistulas

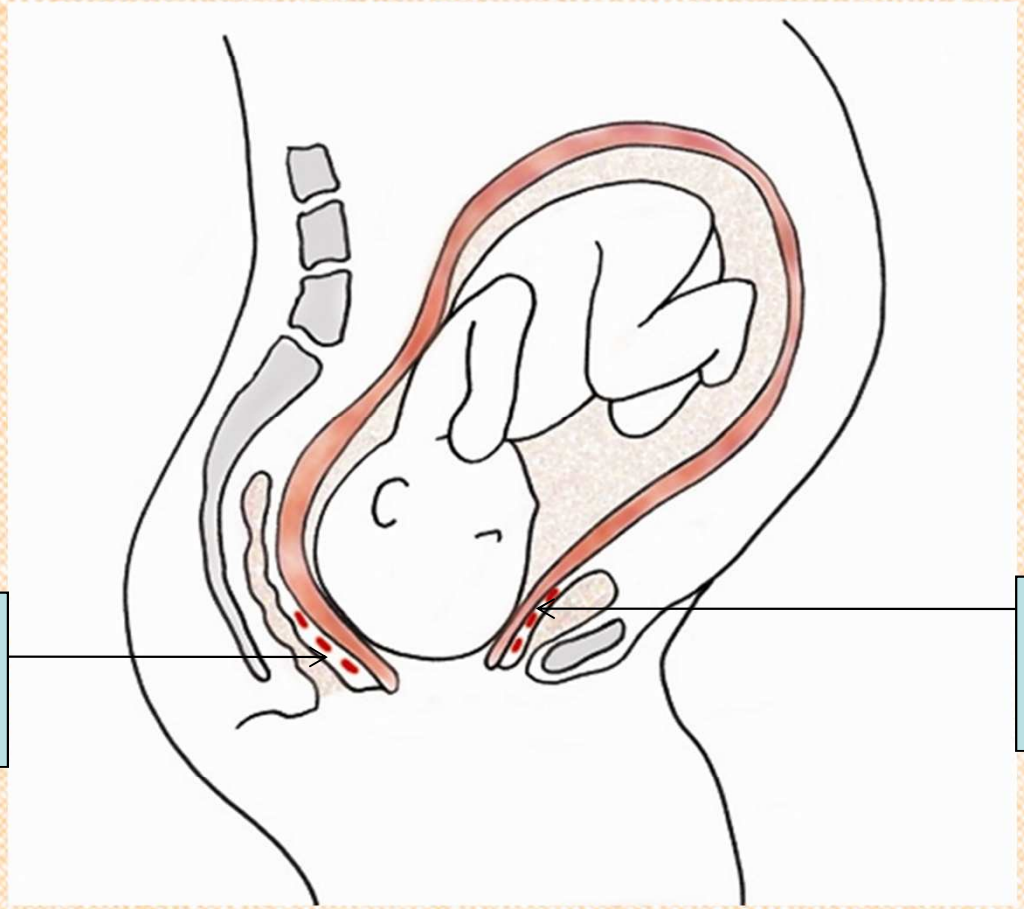

Figure adapted from Fistula Care

Diagnosis of obstetric fistula

- VVF can usually be diagnosed when a woman leaks urine by 1-2 weeks postpartum or after surgery
- Some obstetric fistulas may be obvious as soon as 24-48 hours after delivery (particularly if the fistula involves the anterior wall of the vagina)
- Most women will leak urine continuously but if the fistula is small it may be only intermittent
- Some women will be incontinent of stool

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DIAGNOSIS OF OBSTETRIC FISTULA

Woman presenting with leakage of urine at primary health center

MORE likely to be due to other causes such as stress incontinence	NO	DOES SHE LEAK URINE CONTINUOUSLY?	YES	MORE likely to be due to Obstetric Fistula
LESS likely to be due to Obstetric fistula; MORE likely due to stress incontinence	NO	DID THE LEAKAGE BEGIN SOON AFTER CHILDBIRTH? DID SHE HAVE PROLONGED LABOR AND/OR A STILLBIRTH?	YES	MORE likely to be due to Obstetric Fistula
MORE likely to be due to Obstetric fistula	NO	DOES URINE PASS THROUGH URETHRAL OPENING WITH SUPRAPUBIC PRESSURE?	YES	LESS likely to be due to Obstetric Fistula
LESS likely to be due to Obstetric fistula	NO	PERFORM CAREFUL PELVIC EXAM WITH SPECULUM: IS AN OPENING VISIBLE ON THE WALL OF THE VAGINA? PALPATE: CAN ANY OPENING(S) BE FELT WITH A FINGER?	YES	DIAGNOSE Obstetric fistula
Consider referral for examination under anaesthesia if urine leakage persists	NO	INJECT DILUTED METHYLENE BLUE DYE THROUGH FOLEY CATHETER INTO BLADDER — DOES THE DYE STAIN A GAUZE PLACED IN THE VAGINA?	YES	DIAGNOSE Obstetric fistula
Likely to be Obstetric fistula requiring surgical repair	NO	IS THE CLIENT LESS THAN 4 WEEKS POSTPARTUM?	YES	This is an Obstetric fistula which MAY rarely heal without surgery – gently debride any necrotic tissue, sitz bath for perineal care, foley catheter x 4 weeks with weekly reassessment, encourage 4 liters fluid intake daily. Recommend surgery if still leaking after 4 weeks.

If NO to all of these questions – simple Obstetric fistula – prepare for repair

NO	DESCRIBE FISTULA: IS THERE MORE THAN ONE FISTULA VISIBLE? IS IT MORE THAN 2 CM IN SIZE? DOES IT INVOLVE THE URETHRA? IS THERE EXTENSIVE VAGINAL SCARRING PRESENT?	YES	If YES to any of these questions, likely to need more complex surgery or extensive preparation for surgery and rehabilitation – REFER for first repair where specialist available
	DOES THE CLIENT ALSO HAVE FOOT DROP OR HIP CONTRACTURES?		
	IS THERE ALSO STOOL IN THE VAGINA OR DOES THE WOMAN COMPLAIN OF BEING UNABLE TO DEFECATE NORMALLY THROUGH THE RECTUM?		

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Preparing for Obstetric Fistula Repair:

NUTRITION
High protein diet, Iron/Folate supplements

LAB SCREENING
Blood type and Hgb, urine microscopy, stool for parasites

TREATMENT
Treat infection if necessary

HEALTH AND HYGIENE
Perineal care 2x day, encourage fluid intake of at least 4 liters water per day, discuss family planning needs

COUNSELING
Will need catheter for at least 2 weeks after surgery, family planning, HIV and hygiene counseling. Inform clients to refrain from penetrative sexual relations for 3 months, and that even after surgery, some women may be wet. Emphasize importance of early antenatal care, skilled attendance and the potential of C/S delivery for any future pregnancies.

References

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Prognostic factors of success of repair

- Degree of scarring and ease of access to the site of the fistula
- Size of fistula and proximity to the urethra and neck of the bladder (where the trigone of bladder muscles are located)
- Whether this is the first attempt at surgical repair
  - 80-95% success with first repair
  - 65% or less success with repeat attempts
- Presence of associated complications such as malnutrition, chronic pelvic or bladder infections

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