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)
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
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
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

Vesico-vaginal

Recto-vaginal

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
JOB AID: 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
- LESS likely to be due to Obstetric fistula; MORE likely due to stress incontinence
- MORE likely to be due to Obstetric fistula

**Decision Tree**

- **NO**
  - **NO**
  - **NO**
  - **NO**
  - **NO**
  - **YES**
  - **YES**

- **YES**
  - **YES**
  - **YES**
  - **YES**
  - **YES**

**Preparation for Obstetric Fistula Repair:**

- NUTRITION: High protein diet, Iron/folate supplements
- LAB SCREENING: Blood type and Rh, urine microscopy, stool for parasites
- TREATMENT: Tissue infection if necessary
- HEALTH AND HYGIENE: Postnatal care 2-3 days, encourage fluid intake of at least 4 liters water per day, discuss family planning needs
- COUNSELING: Urinary catheter for at least 2 weeks post-surgery, family planning advice and hygiene counseling, inform clients to abstain from penetrative sexual relations for 3 months, and that even after surgery, some women may be well. Emphasize importance of early antenatal care, skilled attendance and the potential of C/S delivery for any future pregnancies.

**References**


**FistulaCare**

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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