FISTULA SURGERY

OPTIMUM PRE AND POST-OP CARE
No robust studies (RCTs)

Recommendations are from

“Accepted Practice”
First Visit

Careful history and examination

Respecting the dignity of each woman
Rehabilitation

(A most important outcome)

Begins at first visit
SOME STARK FACTS

- 850 Million people will go to bed hungry tonight
- 1 Billion today lack access to safe drinking water
- 10 Million children will die this year before their 5th birthday
- 0.5 Million mothers (1 per min) will die in childbirth (<1/2 of 1% of these will be in Developed World) while many suffer serious morbidity - all because appropriate emergency obstetric care is not available (nor accessible) to those who require it.
Pregnancy history

How many children alive?
Gentle vaginal examination
(1 finger)

Exaggerated left lat. (Sims’) to view VVF

Gentle P.R. – leakage may not be volunteered
Bladder stones felt with metal catheter
Counselling / Explanation

Removal of stones → interval → weeks later, repair

Why advise colostomy?

Counselling re HIV

Advisability of any diversion procedure
Pre- Op

Water: drinking (boiled), other fluids, washing

Soap: washing pre and post-op

Soap powder for clothes
Keep Ambulated

Foot drop
Prevent / treat pressure sores
Soiling during surgery seems increased with ‘late’ enemas
RVF

If no colostomy, have enema

Fluids (oral only) for 2 to 3 days
Anaesthesia guidelines agreed by the team, with advice from anaesthesiologist, about what to do when certain problems arise. (Someone capable of intubation).
Beware, that in treating a maternal morbidity we do not end with a mortality
Post-op

Nurse on alternate sides, change 4 hourly and always look towards drainage receptacle(s)

Encourage fluids

No food for RVF till day 5
Analgesia

Pethidine 50 mg I.M.
4 hourly
KEEP
PATIENT
CLEAN
Drainage of Bladder

Balloon no more than 10 ml.

No kinks in catheter or tubing
Bag or receptacle at lower level than bladder

‘Water flows down, not up, hill’
Beware waist belt or cord
Avoid ‘trousers’ pre and post-op

Aim to get as much air as possible to vulva

Maintain dignity with long wide skirt
Closed or open drainage system?
Prophylactic antibiotics

No satisfactory RCTs in fistula surgery
If given, give appropriate antibiotics

I.V. at induction of anaesthesia
Specific problems

No or little urine
Blood stained urine
Ureteric catheters
Rectal tube
‘Early’ closure

Numerically not a significant problem in developing world – many seek treatment after years

Spontaneous healing

Check catheter position

Most studies at 2 months – not early

Where fail, success rate subsequently decreased
The best time to cure fistula is at the first attempt.
Prevention is the Best Treatment
Catheter Drainage

- Early – tip: not in vagina
  balloon not keeping fistula open

- Early and late – not more than 10ml balloon
Waiting period 2-3 months

- Tissues become healthier and less friable
- Infection can be eradicated
- Waiting hostel
- Physiotherapy
Other Clinical Problems

- Severe anaemia
- Severe malnutrition
- HIV infection
Involved in prevention and treatment strategies
Clinicians can learn so much from collaboration with, and guidance from, colleague(s) in Public Health and Epidemiology
We owe it to the poor women who suffer, to obtain robust scientific evidence so that we may inform correct, appropriate health care policies at regional, national and international levels.