Management Of Total Urinary Incontinence In Females A Two Years Experience

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A prospective study of 7 cases in Urology Department at Sir Ganga Ram Hospital Lahore was carried out from September 1994 to September 1996. All patients presented with urinary incontinence (100%). One patient (14.3%) was having associated pain Left Lumber Region and one (14.3%) pain Left Iliac fossa. The age varied from 14 to 40 years, with mean age of 28 years. Six patients (85.7%) were having ureterovaginal fistulae and one (14.3%) a vesicovaginal fistula. One (14.3%) of the ureterovaginal fistulae was result of a congenital opening of one of the double ureters in the vagina. One (14.3%) resulted from involvement of ureter in a growth. Four (57.1%) of the ureterovaginal fistulae and one (14.3%) vesicovaginal fistula were result of some obstetrical surgery. In all the cases of the ureterovaginal fistulae, the ureters were implanted in urinary bladder with D.J. Stent, while vesicovaginal fistula was repaired with delayed absorbable vicryl 2/0. The results were 100%.

Key Words: Vesicovaginal fistula, Ureterovaginal fistula, Genitourinary fistula, Vicryl, D. J. Stent (Double J. Stent)

Genitourinary Fistulae in women have existed since time immemorial and have remained a major problem in our country, 85% of Genitourinary Fistulae follow obstetrical complications like obstructed labour, instrumentation, and lower segment caesarian section[1]. While operations for benign diseases, malignancies and radiotherapy account for the remainder[2].The purpose of this study was to evaluate the incidence, age, mode of presentation, predisposing factors management and results of surgery in genitourinary fistulae in females.

Methods and Patients

The study was conducted in Urology Department at Sir Ganga Ram Hospital Lahore from September 1994 to September 1996. All female patients admitted in the unit with total urinary incontinence during two years period were included in the study. Detailed history and Complete Examination were entered in a proforma. Routine Investigations, Intravenous Urogram, Ultrasonography, Urethrocystoscopy, Methylene Blue Test with vaginally placed tampons, voiding cystourethrogrames and Retrograde urography whenever indicated were performed. The vesicovaginal fistula repaired through vaginal approach by flap splitting method, the suture material used was vicryl 2/0. Retropubic drain and folley catheter were used in all cases of ureterovaginal fistulae. All the procedures were covered by Aztreonam 1G, i/v 12 hourly, preoperatively and post operatively for three days and later on ofloxacin 200 mg BD for one week. The drain and catheter in ureterovaginal fistulae were removed on 5th post operative day while in vesico vaginalfistula the catheter kept for two weeks.

Procedure

Ureterovaginal fistulae repaired through retroperitoneal approach under G/A, mobilizing the ureter and urinary bladder then stitching the urinary bladder to psoas muscles (psoas hitch) and reimplanting the ureter with D.J Stent.

Results

Total number of patients were seven. All were female. Age ranged from 14-40 years mean age 28 years. 6 (85.7%) of the patients belonged to rural and one (14.3%) to urban area. 5 (71.4%) of the patients were uneducated while 2(28.6%) were educated. 4 (57.1%) of the patients were operated in non-teaching hospitals of periphery and one (14.3%) in teaching hospital of Lahore. Genitourinary fistulae as a result of surgical complications were 5 (71.4%). While one (14.3%) of the patients had a congenitally double ureter and one of the ureter was opening in to the vagina and one (14.3%) of the patients had an ovarian growth involving lower end of left ureter that lead to development of ureterovaginal fistula later on. Involvement of the ureter on left side was in 4 (57.1%) patients and on right side in one (14.3%), while the one (14.3%) congenital double ureter was also on right side. In one (14.3%) of the patients both of the ureters were involved.

Discussion

Female incontinence is a disease of child bearing age[2] as age ranges from 14-45 years in this study which is maximum fertile period in females. In our country 71% to 80% of genitourinary fistulae result from obstetrical operations[1,2] though in developed countries, the main cause of urinary fistulae in females is radiotherapy and malignancy[3,4], in contrast to our experience and some of others [5].

Most of the patients (71.4%) in our study are uneducated compared to 70% as mentioned by Altaf Bashir et al in 1995 in her series of 20 cases. While 85.7% of the patients are having a rural background as compared to a figure of 85% mentioned by Altaf Bashir et al in 1995[2].

The interval between injury and repair in 60% cases were more than 6 months while 2 patients (28.6%) were operated immediately and one (14.3%) was a congenital ureterovaginal fistula. Though opinions regarding timing of repair remain controversial. Accepting the dictum that the

best time to cure a fistula is at the first-operation, it is generally advised to repair three months after injury[6] because spontaneous closure may occur in a fistula of the size of less than 3 cm following continuous bladder drainage for two to three weeks[7,8].

Success rate (85%) in general is usually expected at first attempt[1] but we achieved 100% success rate due to good pre-operative preparation, meticulous operation technique, good assistance, correct suture material and very keen post operative care.

Conclusions:

1. Genitourinary fistulae in Pakistan are mainly a result from obstetrical complications particularly in uneducated population of villages that get operated in hospitals lacking expertise facilities.
2. The incidence can be reduced by community education, good maternal care and identification of high risk patients for difficult labour and their proper and in time referral to equipped centers.

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