TREATMENT OF INCONTINENCE FOLLOWING REPAIR OF VESICO-VAGINAL FISTULAE

G. P. CHARLEWOOD, F.R.C.S. (EDIN.), F.R.C.O.G., *Johannesburg*

Those gynaecologists who repair large numbers of vesico-vaginal fistulae will appreciate the frustration of finding the patient as wet after a successful closure of the fistula as before. This is partly due to damage to the bladder sphincter by the original sloughing process, and partly to the tough scar tissue uniting bladder to vagina, which prevents the bladder neck from closing properly.

Numerous methods have been used in correcting this defect, none of them satisfactory. The Marshall-Marchetti operation[1] (1949), which is so successful in other types of stress incontinence, fails because it cannot overcome the resistance of the scar tissue. In the occasional case where the whole vagina has sloughed away the anal sphincter can be used with success.[2] Sling operations[3,4] are liable to reopen the fistula.

In 18 cases I have found the operation described here to be a simple and satisfactory answer to this problem.

Two loops of chromic catgut are passed round the pubic rami by means of a long curved needle as indicated in the diagram. Each is tied tightly in the bed of a shallow vertical incision over the healed fistula, as indicated. This has the effect of overcoming the resistance of the scar tissue to whatever sphincter action remains. It certainly gives excellent results. Obviously where gross destruction has occurred to the bladder neck and the patient is quite incontinent, complete control cannot be expected, but even in these cases, if the patient is finally left in a condition where she has a dry bed at night and only loses urine when coughing or straining, then she and her medical attendant have every reason for satisfaction.

This operation was used in 18 cases. In 14 of them the result was considered completely satisfactory and the patient was discharged. In 6 the operation was repeated because improvement was not considered sufficient, or because incontinence recurred. In 2 severe cases the operation was carried out 3 times, with a satisfactory final result. In 1 case the fistula reopened where the stitch passed over the scar, but this was successfully closed and continence was excellent.

There was no case which did not greatly benefit from the operation.

This operation was also tried for routine treatment of stress incontinence (apart from vesico-vaginal fistula) but while it gave good results it was thought to be too hazardous because of occasional haematoma formation in the space of Retzius, which required drainage. Non-absorbable suture material was originally tried but this caused trouble with sepsis and should not be used.

Summary. A simple and successful operation is described for the hitherto intractable incontinence which may follow repair of a vesico-vaginal fistula.

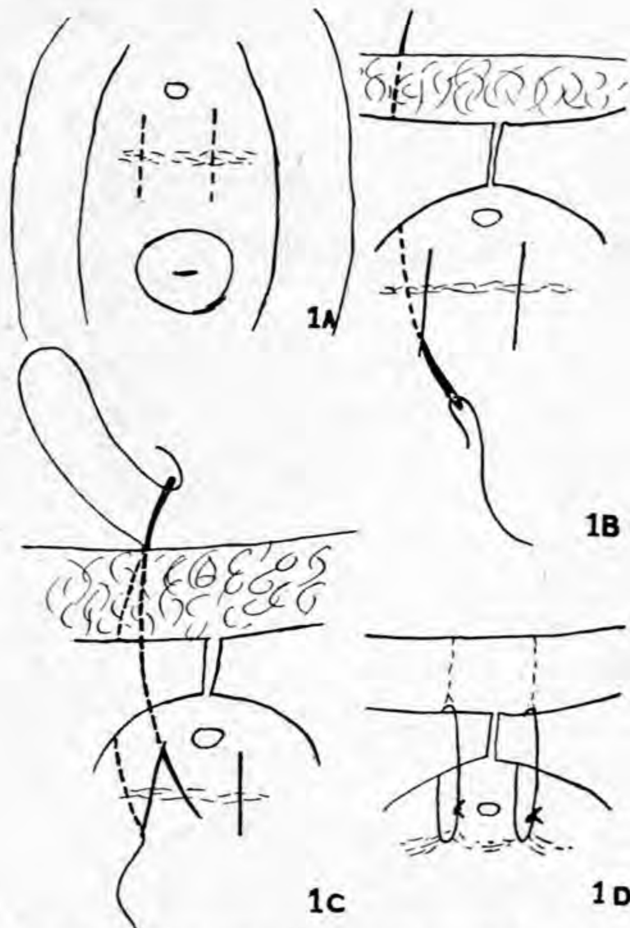

Fig. 1. Operation for incontinence from post-vaginovesical fistula.

A. The dotted lines show the site of the two incisions at level of bladder neck. The scar of the healed fistula is shown.

B. A 5-inch curved Bonney needle, threaded with No. 2 chromic catgut, is inserted at the posterior end of the incision and is passed behind the pubic bone to emerge through the skin. (The abdominal skin is stretched upwards with the hand to make the puncture as low as possible.)

C. The needle is reinserted in the same puncture mark and is passed anterior to the pubic bone to emerge at the upper end of the incision.

D. The procedure is repeated for the other incision and the sutures are tied tightly. Vaginal skin sutures are not needed.

REFERENCES

1. Marshall, V. F., Marchetti, A. A. and Krantz, K. E. (1949): Surg. Gynec. Obstet., **89**, 509.
2. Charlewood, G. P. (1954): S. Afr. Med. J., **28**, 15.
3. Aldrich, A. H. (1942): Amer. J. Obstet. Gynec., **44**, 398.
4. Millin, T. and Read, C. (1950): *Modern Trends in Obstetrics and Gynaecology*, p. 697. London: Butterworth.