The Obstetrical Vesicovaginal Fistula Still an Ongoing Tragedy of Developing Countries

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Objective: To investigate the causes of Obstetrical Vesicovaginal fistula in mothers of developing countries.

Methods: It is a descriptive study in which 56 patients with obstetric vesicovaginal fistulas were included in the study from Ist Jan 2006 to 31st December 2008. It was carried out at Lady Willingdon Hospital, Lahore in Gynae /Obstetric unit-I.

Results: There were 56 patients included in this study. 67.8% patients were in 21-29 years of age group. Only 17.8% patients received some kind of antenatal care, obstructed labour was seen in 71.4% of cases, 48.2% of patients were primigravidas. Caesarean sections were done in 12.5%, of cases caesarean Hysterectomies were done in 17.8% of cases, and forceps deliveries were carried out in 5% of cases only.

Conclusion: The obstetrical Vesicovaginal fistula is still a tragedy of mothers in developing countries Antenatal Care, management of labour by appropriate and skilled persons, centralization and training of specialists for repair of fistulas are the key elements to fight against such mishaps.

Key Words: Obstetric Fistula, Vesicovaginal (VVF), morbidity.

Introduction

Vesicovaginal fistula is an abnormal communication between vaginal and bladder epithelial surfaces. Vesicovaginal fistula represents a great challenge to obstetrician and urologist even in this era of developments and research.

It is the uncontrolled leakage of urine from bladder to vagina, causing incontinence which is the hallmark symptom of this problem .it leads to discomfort and malodur which causes serious social consequences.

In developed countries, the most common cause of obstetrical VVF remains iatrogenic injury to bladder during Gynaecological surgery.[1] Obstetrical VVF due to obstructed labor has long been eradicated from the developed world.[2,3]

In social terms, the obstetrical fistula arises usually due to early marriage, child bearing before a young girl's pelvis is adequately developed, lack of women's prenatal and obstetrical care, poverty, residences in rural areas and lack of trained birth attendants.

At a wider level, it has been seen that advent of modern obstetrical care has lead to eradication of obstetrical fistulas in developed countries. However in developing countries, it is on the top of list of maternal morbidities still causing untold pain and suffering in millions of women. It occurs due to societal and institutional neglect of women which is by standards, an issue of human rights and equity.[4]

The prevalence of this tragedy in women, lack of timely repair, social rejection and suffering of untreated and even the stigmatization of treated women represents a great violation of human rights as well.

Materials and Methods

It is a descriptive study carried out in Gynae unit-I of Lady Willingdon Hospital, Lahore from Ist Jan 2006 to 31st December 2008. There were 56 patients with obstetrical VVF during this period.

Information about the cases with obstetrical fistula was collected with the help of Proforma which included parity, age, etiological factors, duration and size of fistula.

Results

A total of 56 patients with obstetrical VVF were seen during this period and results are presented as:

Table 1: *Distribution of women with obstetrical VVF according to age group n=56.*

Age of patients	Number of cases	Percentage
< 20 years	8	14.2%
21 – 29 years	38	67.8%
30- 39 years	9	16%
> 40 years	1	1.7%

Table 2: *Causes / Etiological factors in obstetrical VVF n= 56.*

Causes	Number of patients	Percentage
Obstructed / Prolonged labour	36	64.2%
Lower Segment Caesarean sections	10	7.8%
Caesarean Hysterectomies	7	12.5%
Forceps deliveries	3	5.35%

Table 3: *Booking status of women with obstetrical VVF n=56.*

Status	No of Patients	Percentage
Booked Patients	10	17.8%
Un-Booked Patients	46	82.14%

Table 4: *Duration of Labour in women with VVF n=56.*

Duration of Labour	No of patients	Percentage
< 24 hours	4	7.1%
24 – 72 hours	12	21.4%
> 72 hours	40	71.4%

Table 5: *Parity distribution in obstetrical VVF patients n=56.*

Parity	Number of Patients	Percentage
1	27	48.2%
2	13	23.2%
3	8	14.2%
4	5	8.9%
5	3	5.3%

Table 6: *Place of labour in obstetrical patients with VVF n=56.*

Place	Number Patients	Percentage
Home deliveries	35	62.5%
Health Centres	10	17.8%
Private hospitals	9	16.07%
General hospital	2	3.5%

Discussion

Obstetrical VVF remains an ongoing tragedy of motherhood. It was seen in this study that mostly the patients were between the age group of 21-29 years and corresponds to 67.8% of total VVF cases. They were young patients who were managed by traditional birth attendants and Dais at remote areas.

17.8% of patients were those who received some kind of antenatal care, But 82.14 5% did not receive any kind of antenatal care by a appropriate health personales, showing the role of antenatal care in prevention of such catastrophies.

Duration of labor was also included in this study to know about the role of time duration of labour in causation of such problem. 71.4% of patients had labour > Three days indicating the role of prolonged and obstructed labour in causation of obstetrical VVF. Mostly the patients with such kind of labour had fistulas in Juxtacervical region which is probably due to the fact that obstruction in labour at pelvic brim is the commonest cause of VVF.[6,7]

The role of parity was also studied in this study. Mostly the patients with VVF were primigravidas (48.2%) who were usually teenagers with inadequate pelvic development and poorly managed labour showing the importance of place of births in such patients.

Causes of VVF were obstructed labour in 64.2% of cases, caesarean section usually in peripheral private hospitals included 17.8% of cases. Cesarean hysterectomies were seen in 12.5 % of cases 5% of patients were those who were delivered by forceps.

This study also reflects the importance of Antenatal booking, hospital delivery by trained persons, and operation by appropriate trained surgeons for the prevention of such mishaps.

Conclusion

VVF is still an ongoing tragedy of women in developing countries, efforts must be intensified on prevention of prolonged and obstructed labor which is the leading cause of VVF.[8,9] It must be accompanied by improvement in socio-economic status of women, free antenatal care, safe mode of delivery and readily available emergency obstetrical services by trained personales.[10-12] Prolonged catheterization after obstructed labour must be emphasized as well.

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