

AN ATYPICAL NEGLECTED CASE OF GENITOURINARY FISTULA MIMICKING UTERO-VAGINAL PROLAPSE

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OBJECTIVE

To report an atypical presentation of neglected genitourinary fistula, which presented as genital prolapse, and acute pain in the lower abdomen for avoiding diagnostic dilemmas and proper monitoring of such patients.

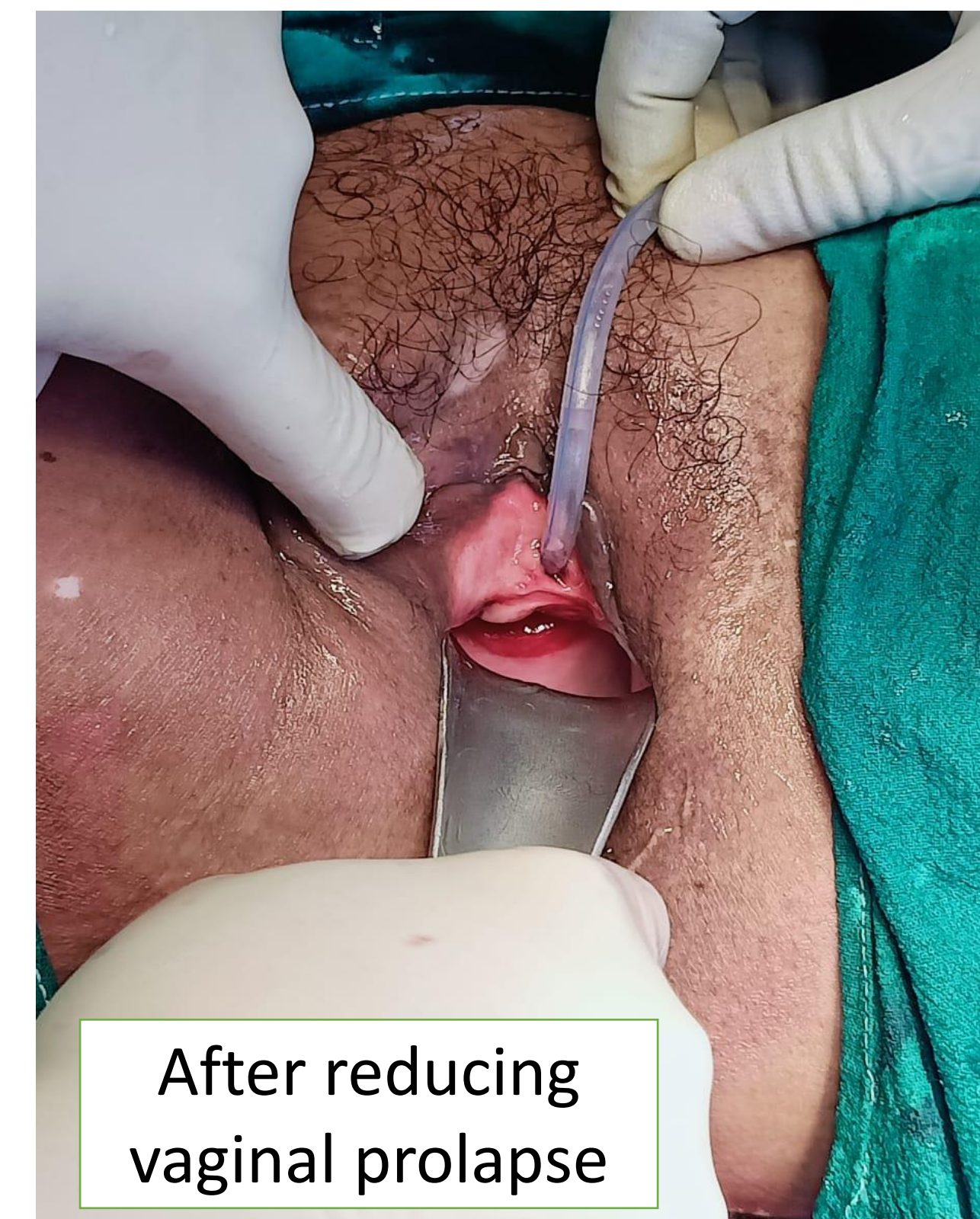
CASE REPORT

Pelvic fistulas are abnormal tracts that exist between the vagina or perineum and other organs like the bladder, urethra, ureters, colon, or rectum. The most common cause of genitourinary fistulae worldwide is obstructed labor.[1]

A 50-year-old postmenopausal woman, para 5, live 4 presented in the outpatient department with complaints of urinary incontinence, something coming out per vaginum, and pain in the lower abdomen for 4 years. She had urinary incontinence after her last childbirth, which was difficult home delivery of a dead baby 4 years back. She consulted a rural health center for the dribbling of urine but was referred to a higher center for further management and follow-up. However, due to their poor socio-economic status and lack of awareness, she presented late for seeking treatment when she began to experience excruciating pain lower abdomen over the past few days as a result of prolapsed mass per vaginum. On cystoscopic examination, a defect was seen in bladder, above trigone, sized about 3x3cm which was communicating with anterior vaginal wall, and then under cystoscopic guidance, foleys catheterization was done and left for 4 weeks to decrease inflammation in bladder mucosa. Tab Mirabegron and tab solifenacin was given for 4weeks. The abdominopelvic approach of repair was adopted . Laparoscopic vesico-vaginal fistula repair was done by urology team after 4weeks. Both vaginal and bladder defect was repaired separately with vicryl 3-0, and then omental patch was placed in between the two defects. Bilateral ureteric catheterization was done for 2weeks. Patient was discharged after 5days with regular dose of antibiotic, tab solifenacin and asked to review after 2weeks for ureteric catheter removal.



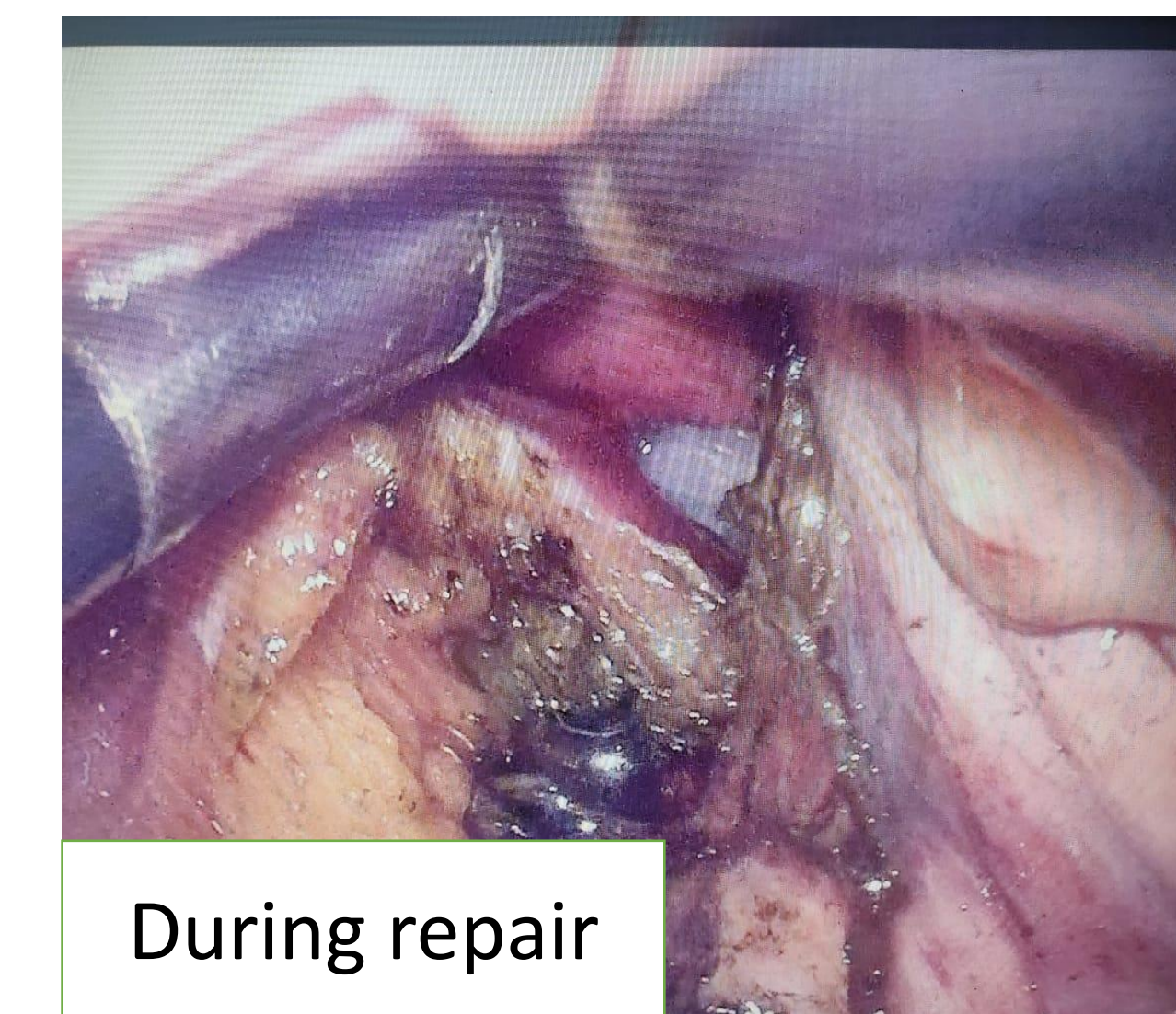
In OPD, presenting with vaginal prolapse



After reducing vaginal prolapse



laproscopic view of fistula



During repair



After repair

DISCUSSION

Obstetric fistulas are a dreaded complication in the puerperal period in low-income countries because of the lack of skilled birth attendants and affordable treatment of fistulas. In developing countries, incontinence often persists due to bladder neck and urethral sphincter injury, abnormal detrusor activity, vaginal strictures, and fibrosis of the bladder[2]. Regardless of etiopathology, development of vesicovaginal fistula has profound And devastating consequences for the patients physical and psychological health.

CONCLUSION

In resource-poor settings strengthening intrapartum and postpartum care and follow-up in the puerperium may facilitate prevention, early diagnosis, and timely management of obstetric fistulas in complicated vaginal births.

REFERENCES

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2. Wall LL. Obstetric vesicovaginal fistula as an international public-health problem. Lancet 2006; 368:1201.