Case report

Genitourinary fistula affixed to uterovaginal prolapse

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Case report: Obstetric genitourinary fistulas 3 [rectovaginal fistula (1), vesicovaginal fistula (2)] all as a consequences of difficult unattended labor in domiciliary settings (eventually with the imminent consecutive vaginal deliveries) congregated by uterovaginal prolapse in two cases giving dual problems of rectovaginal and vesicovaginal fistula with prolapse has been described.

A difficult labor in the outset complicated with severe perineal trauma could form a basis for uterovaginal prolapse.

Key words: Obstetric genitourinary fistulas, uterovaginal prolapse, perineal trauma

Introduction

Genitor urinary fistula primarily represents consequences to a poor or substandard obstetric care caused by obstructed labor in majority of the cases (95%) with profound morbidity as has been reported in some complex fistula.[1,2] A very small component is formed by rectovaginal fistula which came around to 13% of the total 193 genitourinary fistula [(4.7 %) alone and (8.3 %) occurring together with vesicovaginal fistula (VVF)]. The etiologies in 38 cases of rectovaginal fistulas in women aged 17 -70 years were contributed more than half by obstetric trauma in 21 patients (55.2%), post-surgical in 5 (13.1%), traumatic in 5 (13.1%), post radiotherapy in 5 (13.1%) and malignancy in 2 (5.2%).[3] Unrecognized obstetric injury by forceps at the time of delivery have been identified later on after breakdown of the perineal tears repairs because of fecal contaminations and infections in 21%.[4,5] We report two cases of uterovaginal prolapse associated with genitor urinary fistula from reproductive morbidity camp.

Case 1

A 45 years old multipara P3 with all the living children gave history of involuntary escape of stool since the birth of the very first average sized breech baby at 23 years. Subsequently there were 2 more deliveries 3 and 5 years later respectively with fecal incontinence bothering her all the time. On the top of this for the past 3 years, was troubled with the emergence of newer problem of total uterovaginal prolapse (procidentia) with the uterus always remaining outside the vaginal introitus, thoroughly smeared by stool all around and over. Her life in Dadeldhura had been condensed to misery but found no place to consult even though she had been facing such a tormenting situation for 23 years which was getting worse by the development of uterovaginal prolapse. She felt helpless as the stool coming within the vaginal orifice could not be prevented from soiling the huge uterus that was irreducible.

On examination, her general conditions were satisfactory, weighed 42 kgs and Blood Pressure was 120/90 mm of Hg. There was a severe degree of uterovaginal prolapse with "procidentia' and the skin over the prolapsed uterus had been dry from outside exposure and also smeared by stool. Prolapsed uterus was obscuring a rectovaginal fistula placed on lower part of rectum close to the anus measuring about 3-4 cms (fig1a & 1b). Through this fistulous opening rectum was visualized that first gave false impression of rectal prolapse. She tested positive for Chlamydia. She refused to undergo any surgical treatment as she was occupied looking after the cattle's.

Case 2

A 40 year old lady, Para $_4$ A $_2$ with 2 living children gave history of continuous dribbling of urine following difficult birth of a term stillbirth in her third pregnancy after a prolonged labor, 18 years back when she was 22 years of age. There after she conceived again but unfortunately had a repeat stillbirth. A history of uterovaginal prolapse for the past 2 months was an additional problem over the existent

Fig. 1a: Uterovaginal prolapse obscuring RVF

Fig. 1b: Rectovaginal fistula seen after insertion of ring pessary

continuous leaking of urine.

On examination she was 157 cms, weighed 40 kgs and the BP measured to be 100/60. There was cervical erosion, uterus being retroverted and normal sized on bimanual palpation. Urine was dribbling from vesicovaginal fistula. Hemoglobin was 11gm% and laboratory investigation did not show any vaginal infection. She was advised to undergo repair of the fistula.

Case 3

A 26 years old multipara P_3 and an illiterate farmer woman gave a sad history of her first pregnancy which culminated in difficult delivery of a stillbirth out of prolonged labor lasting for 4 days followed by continuous leaking of urine (vesicovaginal fistula). In the presence of continuous dribbling of urine she moved on to give vaginal birth at home twice consecutively, aided by her mother both resulting in live birth. Her life for the past 12 years; since as a child of 14 is messed with urine, given in marriage as she just started menstruating conception and delivery occurring at fast succession. She a mother of two surviving children did not have any knowledge that there was surgical treatment for the urinary leakage. On examination blood pressure and pulse both were normal. There was vesicovaginal fistula about 3 cms diameter.

Discussion

It sad to find women living with these kinds of dual problems having their fallen womb messed up with stool and urine for months or years together without looking for the solution and such a combination of genitourinary fistula and pelvic organ prolapse today is an unfortunate tragedy hardly mentioned in the literature.[6-8] It is rare to find genitourinary fistula associated with uterovaginal prolapse of various degrees, one having minimal decensus and the other having severe degrees of decensus and procidentia, both of which occurred after 40 years of life. Both the urinary fistula was from Tarai whereas rectovaginal fistula was from mountainous areas of Dadeldhura amidst 2070 women examined in Reproductive Health Morbidity Camp in the year 2005 -2006 from IOM.

Genitourinary fistulas of obstetric origin have been the consequences of difficult labor in all the three cases mentioned above. Rectovaginal fistula was related to difficult labor which occurred during the process of the first order of birth due to malpresentaion (breech) as easily explained by two consecutive uncomplicated deliveries. While the dual problems of uterovaginal prolapse and rectovaginal fistula had been bothersome for the past three years. In the second case, vesicovaginal fistula occurred during the time of the third birth, in a average sized woman, whose height was 157 cms, probably because of cepahlopelvic disproportion with the baby size much bigger than her pelvis. More surprising is the next uncomplicated birth that followed, in the presence of the fistula, conception occurring few later which relays that urine was not harmful for sperms.

Usually VVF occurs at the time of first birth in primigravida and the occurrence in the third order of birth is rare, while the fourth delivery also occurred culminating in easy home delivery.

All the more disturbing is the fact that none of them had attended delivery during their successive child birth which pursued in concordance with genitourinary fistula. Possible in the first case which had been a complication arising from malpresentaion (breech) which did not repeat. Explainable

in other two keeping background of malposition in mind that could have occurred from cepahlopelvic disproportion, unfortunately with guarded outcome of a repeat stillbirth. Urine basically did not pose harm to sperms.

A nullipara taken care in our own institution for uterovaginal prolapse along with continuous urinary dribbling from VVF apparently had a doubtful look of partial eversion of bladder represented by reddish areas of oozing *(Fig 2).* Cervix was unseen; the fistulous opening whether obscured by the whole mass, was undetermined. Acutely inverted bladder from prolonged labor of obstetric origin have been met and complete eversion of bladder through vesicovaginal fistula could be a running possibility in a massive bladder prolapse like in our case.[9-10]

Fig. 2: Massive prolapse of bladder and uterus

Conclusion

Difficult labor insinuate the problems of fistula and uterovaginal prolapse

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