

A Review Of The Management Of VVF At UTH

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Introduction

Before the 18th Century, treatment of VVF was considered futile. In 1852, James Marion Sims described the first successful repair of VVF using silver wire suture and urinary bladder. This was followed by successful repair in the 20th Century by both vaginal methods (O'Connor) and abdominal method (Tancer).

Epidemiology and Aetiology

In keeping with improved care developed countries, VVF is on the decline. However, in developing countries, which are faced with an increasing birth rate but declining economic growth, obstetric care is poor and VVF is a major problem. In developed countries 90% of fistula follow operative injury, most of which is gynaecological surgery.

In developing countries the main cause is obstetric. In Africa a special hospital is in existence, The Addis Ababa Fistula Hospital was opened in Ethiopia in 1975. Cases treated in 1987 and 1997 were 603 and 1200 respectively. Currently an average of 40 VVFs are repaired weekly with a success rate of 90%. It is estimated that there 500,000 untreated cases worldwide.

Pathogenesis

Obstetric fistulas result from obstructed usually in young women with a pelvis that is not fully developed. The foetal head compresses the anterior vaginal wall against the bladder base onto the pubic bone, resulting in pressure necrosis. Delivery is usually by Caesarian section or instrumentation; usually incontinence presents after 10 days.

Background

The University Teaching Hospital (UTH) in Lusaka is a 1600 bed hospital and is the main teaching and referral centre in Zambia. It serves a population of just over 10 million people. Two urology units practice at the centre. Many VVFs are regularly repaired but no previous studies have been done to document the numbers, pattern and success rates. It was for this reason that a 5-years retrospective study was undertaken by one of the two urology units at the UTH.

Patients and Methods

All patients seen at Urology Unit 2 at UTH between January 1996 and December 2000 were included in the study. The patients' records were studied with a view of determination of:

1. The number of VVF cases seen over the period under review,
2. The common aetiology, presentation, management and outcome and
3. The success rate of operative repair of VVFs.

Results

Over the 5-year period under review, a total of 1658 urology patients were seen. Of these, 45 (2%) presented with VVFs. Table 1 shows the causes of the VVFs.

The VVFs were high in 18 patients, low in 12 and irreparable in 9. VVF repair was transabdominal in 18 cases and was transvaginal in 12 patients. Urine diversion was performed in 9 patients.

Recurrence occurred in twelve of the 45 patients who had VVF repair; occurred within 1 month and was mostly in the low fistulas among patients aged 15-35 years. The overall success rate was 73%.

Table 1. Aetiology of VVFs at UTH and in developed countries.

Cause	UTH	Developed countries
Obstetric	100%	0%
Gynaecological	0%	90%
Oncology	0%	10%