3ème/rd Conference

International Society of Obstetric Fistula Surgeons

Obstetric Fistula International Conference

ISOFS 2010

December/Décembre 7 - 9, 2010

Hôtel des Almadies (ex Club méditerranée)
Dakar-Sénégal

"Preventing women from becoming outcasts"
"Préserver les femmes de devenir des paria"

07- 09 december / décembre 2010

UNFPA · The Fistula Foundation · Johnson & Johnson · Ministère de la Famille des Organisations Féminines et de la Protections de l'Enfance · EngenderHealth for a better life · Ministère de la Santé, et de la Prévention · WAHA · Liberté • Égalité • Fraternité République Française

WELCOME ADDRESS

Dr Kees WAALDIJK
President ISOFS

Prof Serigne Magueye GUEYE
Chair Organizing Committee

We are pleased to welcome you in Senegal, for the 3rd Annual Conference of the International Society of Obstetrical Fistula Surgeons (ISOFS) that will be held from December 7-9, 2010 at hôtel des Almadies, Dakar, Senegal

It will be a wonderful opportunity for fistula surgeons, health care professionals, scientists, advocates and organizations working on maternal and reproductive health to share their experiences in fistula care, training and research. The meeting will incorporate key note lectures, symposia, oral presentations, posters and workshops on obstetrical fistula in the developing world.

The training and research needs in obstetrical fistula will be addressed through lectures, workshops and panel discussions. This year conference will see the finalization of the FIGO-led competency based training manual. In fact, there are lots of training models and huge amounts of money are being invested in fistula training but these efforts are yet to be transferred to the benefit of the global fistula community, especially to services for the benefits of patients suffering from obstetrical and non obstetrical fistula.
ISOFS 2010 also offers opportunities for establishing global partnerships that will lead to better address the needs in fistula care in general.
At the end of the conference, participants will have the opportunity to work together to develop an action plan for fistula care, training and research.
So, please come share your experience but moreover let's move together in an action for fistula prevention and care.

You are all welcome. No doubt that you will enjoy your stay in Senegal, land of "TERANGA"


Obstetric Fistula International Conference
ISOFS 2010
December/Décembre 7 - 9, 2010

INTERNATIONAL SOCIETY OF OBSTETRICAL FISTULA SURGEONS (ISOFS)
3rd Annual Conference / 3ème Conférence annuelle

Hôtel des Almadies (Ex-Club Méditerranée)

DAKAR, SENEGAL

December/ Décembre 7 – 9, 2010

INTERNATIONAL OBSTETRICAL FISTULA WORKING GROUP MEETING

Hôtel des Almadies (Ex-Club Méditerranée)

DAKAR, SENEGAL

December / Décembre 5 – 6, 2010

Congres Secretariat / Secretariat du congrés

ISOFS DAKAR 2010
BP 6039 DAKAR, SENEGAL
Telephone: (+221) 338694061 or (+221) 301023095 Fax: (+221) 338273819
E-mail: isofsdakar2010@gmail.com
Website: www.isofs2010.org

CONGRES LOC CHAIR / PRESIDENT DU COMITE D'ORGANISATION

ISOFS PRESIDENT
Dr kees waaldijk (Nigeria)
kees.waaldijk@yahoo.com
Prof Serigne Magueye GUEYE, MD, FWACS (Senegal)
serigne.gueye@ucad.edu.sn

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REMERCIEMENTS

- UNFPA
- ONG TOSTAN
- HÔTEL DES ALMADIES
- PRESIDENCE DE LA REPUBLIQUE
- MINISTRE DE LA SANTE ET DE LA PREVENTION
- MINISTRE DE LA FAMILLE
- UNIVERSITE CHEIKH ANTA DIOP DE DAKAR
- AMBASADE DE FRANCE

ISOFS 2010 PROGRAMME SCIENTIFIQUE

7/12/2010			
08:00		**Inscriptions**	
08:00 13:00	Salle A	**Réseau des sages-femmes dans la prévention des fistules obstétricales**	**Présidentes :** Mme Ndeye Mareme Fall (ANSFE,Sénégal), Laurence Monteiro (Bénin), Sebastiana Diatta (DSR, MSP, Sénégal)
09:00 13:00	Cours 1 : Salle B	**Astuces dans la chirurgie des FVV**	**Présidents:** Mamadou Bobo Diallo (Guinée), Steve Arrowsmith (USA), Papa Ahmed Fall (Sénégal) • Mamadou Bobo Diallo 10' Introduction • Oumarou Ganda Sanda (Niger) Diagnostique et Evaluation • Kalilou Ouattara (Mali) Classifications • Serigne Magueye Gueye (Sénégal) Principes de la chirurgie de FVV • Theobald Hategekimana (Rwanda) Prise en charge de la FVV simple • Steve Arrowsmith (USA) Prise en charge de la FVV complexe • Igor Vaz (Mozambique) Reconstruction du bassin pour les cas de FVV complexe
08 :00 13 :00	Cours 2 : Salle C	**Atelier sur l'Urodynamique**	**Professeurs :** Paul Abrams, Bristol (UK), Sherif Mourad, Cairo (Egypte), Jeanne Diaw (Sénégal) • Paul Abrams (UK) 15' Introduction • Sherif Mourad (Egypte) 15' Calendrier mictionnel • Paul Abrams (UK) 60' Un aperçu sur l'urodynamique • Sherif Mourad (Egypte) 15' Incontinence due au stress et la VHA -Pause café (30') • Paul Abrams (UK) 30' Interprétation des résultats • Sheri f Mourad (Egypte) 30' Rédiger un rapport • JJ Diaw – Sherif Mourad • Paul Abrams (60') Présentation des cas
14:30 16:00		**Session orale 1**	**Présidents :** Alain Kassim Ndoye (Sénégal), Ambaye Wolde Michael (Ethiopie), Dr John Mulbah (Liberia) • Amir Yola (Nigéria) L'évolution des services de traitement des FVV dans l'Etat de Kano: Une histoire réussie au bout de 20 ans • Sunday Adeoye (Nigéria) Taux de micronutriments parmi des patientes atteintes de FVV dans le nord du Nigéria • Sunday Adeoye (Nigeria)Taux de vitamines parmi des patientes atteintes de FVV dans le nord du Nigéria • Mwangi Judy (Kenya) Quelle est l'accessibilité des services de santé maternelle pour le personnel de santé? Perspectives venant de quatre sites du projet de maternité sans risque de l'AMREF • Raheela Mohsin (Pakistan) Prévalence de l'incontinence urinaire et des facteurs associés ayant un impact sur la vie des femmes en milieu rurale au Pakistan • Stephen Mutiso (Kenya) L'impact du traitement sur la qualité de vie des patientes porteuses de fistules obstétricales à Kisii • Khalid Lawal (Nigéria) Prise en charge des fistules urétéro-vaginales dans un hôpital rural dans le nord du Nigéria • Igor Vaz (Mozambique) Néo-vagin en fistules obstétricales complexes

16 :00 – 16:30 Pause café			
16 :30 17:40		**Session orale 2**	**Présidents :** George Fowlis (La Gambie/UK), Claude Dumurgier (France), Timothée Kambou (Burkina Faso) • Frank Rubabinda Asiimwe (East Africa) Dérivation urinaire par les techniques de “Penn pouch” et Appendicovésicostomie de Mitrofanoff dans la prise en charge des patientes atteintes de fistule obstétricale • Sunday Adeoye (Nigéria) Evaluation des IVU parmi des femmes porteuses de fistules vésico-vaginales dans le sud-est du Nigeria • Sunday Adeoye (Nigéria) Profil des femmes porteuses de fistule accouchant avec les FVV non réparées dans le sud-est du Nigéria.• Joslyn Meier Cartographie des services de traitement de fistule en Uganda à travers les systèmes d’information géographique (SIG • Denis Mukwege (DRC) Fistules gynécologiques en RDC • *Discussion : 10’*
17:40 18:00		**Rapport de l’IOFWG 2010**	Gillian Slinger (UNFPA)
18:00 19:00		**Cérémonie d’ouverture**	• Pr Serigne Magueye Gueye - Président du Comité d’Organisation (5’) • Dr Kees Waaldijk - Président de l’ISOFS (10’) • Rose Gakuba - Représentant de l’UNFPA (10’) • Conférencière (15’) -Gillian Slinger (UNFPA New York) Compagne mondiale pour éliminer les fistules: Progrès et perspectives •- Ouverture officielle 20’
19:00-20:00 Réception			
8/12/2010			
08:00		**Inscriptions**	
08:00 09:30		**Session orale 3**	**Présidents :** Mamadou Bâ (Sénégal), Oladosu Ogengbede (Nigéria), René Hodonou (Bénin) • Amir Yola (Kano, Nigéria) L’incision Yankan Gishiri comme cause de FVV •- Edward Stanford Fistule obstétricale à l’hôpital général de référence de Panzi à Bukavu, RDC: une revue rétrospective de 215 patientes •- Ludovic Falandry (Gabon / France) Traitement des destructions urétrales post-obstétricales •- Sita Millimono (EngenderHealth) Prévention et prise en charge des fistules obstétricales et traumatiques • Richard Manning (Afghanistan) Défis dans le traitement des FO dans un pays en développement •- Gordon Williams La valeur de l’échographie abdominale préopératoire pour les patientes atteintes de fistule obstétricale •- Selashi Legessie Fentaw Education non-formelle des adultes dans la réhabilitation et la réintégration des victimes de fistule •- Gordon Williams “Superbugs” et les patientes porteuses de fistules: Qu’est-ce qu’on doit faire?
09 :30 09 :50		**Conférence de FIGO**	•- Dr. Suzy Elneil Progrès récents en uro-gynécologie
09:50 10:10		**Conférence de PAUSA**	• Khalilou Ouattara Quelques réflexions sur la classification de la FO « Africaine »

10:10 10:55		**Rapport de ICUD sur les FVV**	**Présidents :** Paul Abrams (UK), Serigne Gueye (Sénégal), **Comité :** Mulu Muleta (Ethiopie), Suzy ElNeil (UK), Rahmat Muhamad (Nigéria) **Rapporteurs:** Dirk de Ridder (Belgique), Sherif Mourad (Ethiopie), Alice Emasu (Uganda)
10 :55 – 11 :05 Pause café			
11:05 12:35	Table ronde 1	**Prévention et prise en charge précoce**	**Présidents:** Kees Waaldjik (Nigeria) Alice Emasu (Uganda) René Darate (Bénin) • Anders Seim (Norvège) 10' Expérience de la prévention de fistule au Niger • Mulu Muleta (Ethiopie – WAHA) - Fatouma Mabeye (WAHA) 10' Choix stratégique de WAHA International en matière de traitement, prévention et formation au traitement de la fistule obstétricale • Amir Yola (EngenderHealth) 10' Prise en charge immédiate de la FO • Abubakar Kabiru (Nigeria) - Kees Waaldijk (Nigeria) Prise en charge immédiate de la fistule obstetricale et la prévention de la stigmatisation de la femme par fermeture précoce et traitement par cathétérisme au niveau de l'hôptial Général
12:35 13:00		**Conférence spécial**	**Président de l'ISOFS** • Kees Waaldijk La prise en charge immédiate de la FO fraîche
13 :00 – 14 :30 Déjeuner			
14:30 16:00	Table ronde 2	**Identification des patients - soutien et réintégration sociale**	**Présidents :** Rose Gakuba (UNFPA), Sayeba Akhter Ba (Bangladesh), Kate Grant (USA) • Papa N'diaye (Sénégal) 10' Parcours de la femme porteuse de FO au Senegal • Khady Sy Ba (Mauritanie) 10' Rôle de la Société Civile dans la Prise en Charge de la FO • Aida Tall (DSR, MSP, Senegal) 10' Le Programme Bajenu Gox : une stratégie communautaire de prise en charge des fistules obstétricales au Sénégal.• Joan Kabayambi (Uganda) • Justus Baragelne (Uganda) 10' Causes perçus, le fardeau de la FO et les stratégies d'adaptation des femmes à la clinique de traitement de la fistule à l'hôpital de Mulago, Uganda • Pierre Marie Tebeu - Luc de Bernis - Laurent Bolsrond - Alain Le Duc - Acille Aurèle Mbassi - Charles Henry Rochat (10') Connaissances, attitudes et perceptions concernant la fistule obstétricale parmi des femmes Camerounaise, une étude clinique menée à Maroua, la capitale de province de l'extème nord du Cameroun • - -Anne Caroline Benski - G Stancanelli - Charles Henry Rochat (10') Efficacité d'une stratégie intégrée pour la prise en charge de la fistule obstétricale: Le modèle de Tanguieta au Bénin - Dr Mizanur Rahman - Dr Sayeba Akhter Réhabilitation et réintégration social au Bengladesh
16 :00 16 :20		**Conférencier invité**	• Abdelatif Bencherkroun (Maroc) Dérivations urinaires continentes dans les FVV graves
16 :20 – 16 :30 Pause café			
16 :30 16:50		**Conférencier invité**	**Présidents :** Alain Le Duc (France), Gordon Williams (Ethiopie), Cheickna Sylla (Sénégal), Steve Arrowsmith (USA) 10' Multi-résistance bactérienne aux médicaments et la patiente atteinte de FO • Jérome Blanchot (France) 10'Incontinence après FVV • Ludovic Falandry 10' L'incontinence résiduelle des urines après fermeture de fistule obstétricale • Cecile Haspels (Netherlands) L'incontinence urinaire et fécale postopératoire après la fermeture de FVV/FRV • Discussion : 20 '
16:50 18:00	Table ronde 3	**Prise en charge des complications de VVF**	- **Alain Le Duc (France)** Mécanismes de continence chez les femmes

9/12/2010			
08:00		**Inscriptions**	
08:00 09:30		**Session orale 4**	**Présidents :** Kalilou Ouattara (Mali), Ludovic Falandry (Gabon), Khisa Wakasiaka (Kenya) • Yahya Ould Tfeil (Mauritania) 10' Prise en charge des FVV a Nouakchott: A propos de 50 cas • Habtemariam Tekle (Ethiopie) 10' Une analyse retrospective de 315 cas de fistule recto-vaginale • Habtemariam Tekle (Ethiopie) 10' Déchirures périnéales du troisième et quatrième degré, leur présentation, étiologie et prise en charge • Mulu Teka (Ethiopie) 10' Qu'est-ce qu'il faut pour renforcer l'accès aux services de santé en milieu rural en Ethiopie? Une étude communautaire • Mark Barone (EngenderHealth) 10' Indices des résultats de la fermeture des fistules urinaires au niveau des structures • Molly Melching (Tostan, Sénégal) Autonomisation des femmes et des communautés afin de prévenir la fistule et les pratiques traditionnelles néfastes • Luc de Bernis (UNFPA) 10' L'importance de la qualité de la fermeture de la FO • Discussion : 10 '
09 :30 09 :50		**Conférence de la FASULF**	• Beatrice Cuzin (France) FVV en Afrique : Etat des lieux, problématiques en santé publique et en aide humanitaire
09:50 10:10		**Conférence de SIU**	• Serigne Magueye Gueye (Sénégal) Perspectives globales sur le traitement et la formation à la réparation de fistules dans les pays en développement
10 :10 – 10 :20 Pause café			
10:20 13:00	Table ronde 4	**Formation**	**Présidents:** Hamid Rushwan (FIGO), Luc de Bernis (UNFPA), • Pr Oumarou Ganda Sanda (Niger) 15' L'expérience africaine francophone au Niger • Pr Oladosu Ogengbede (Nigéria) 15' L'expérience africaine anglophone au Nigéria • Pr Sayeba Akhter (Bangladesh) 15' L'expérience asiatique • (A préciser) 15' L'expérience soudanaise • Joseph Ruminjo/Isaac Ashwal (Engender Health) 15' Un aperçu sur les modèles de formation • Charles-Henri Rochat (GFMER-Switzerland) 15' Les bases de données en ligne • Pr Gordon Williams (Ethiopie) 20' Evaluation chirurgicale dans la formation au traitement de la fistule • Dr Sohier Elneil (UK) 20' Le concept du manuel de formation basée sur les compétences • Conclusion: 15'
13 :00 – 14 :30 Déjeuner			
14:30 15:40	Session orale 5	**Surgical outreach /Campagne chirurgicales**	**Chairs :** César Akpo (Bénin), Tom Raassen (Kenya), Jean Marie Colas (France) • Justus Kafungo Barageine (Uganda) 10' Les camps de traitement de la FVV - la façon de prendre en charge les cas accumulés de FVV: L'expérience de l'équipe FVV de Mulago • Tamou Blo - Igace d'Oliveira - René Daraté - Serigne Magueye Gueye - René Hodonou - Akpo Cesar (10') Formation en réparation de la FO au Bénin • Kalidou Ouattara (Mali) 10' Bilan des campagnes nationales et sous-régionales de prise •

14:30 15:40	Session orale 5	**Campagnes chirurgicales**	• Issa Labou El hadj Ousseynou Faye - Lamine Niang-Mohamed Jalloh - Madina Ndoye-Jean Charles Moreau Activités des prises en charge chirurgicales des fistules obstétricales au Sénégal • Filiberto Zattoni (Italie) 10' Expérience de l'activité de prise en charge des fistules à Ngozi, Burundi • Valentin Vedandi – Henry, Benoit Projet de prise en charge des FO à Abéché (Tchad) • Discussion 10'
12:35 13:00		**Conférencier spécial: Président de l'ISOFS**	
13 :00 – 14 :30 Déjeuner			
15:40 17:00	Table ronde 5	**Recherche en FO**	**Présidents :** Mulu Muleta (Ethiopie), Steve Arrowsmith (USA), Joseph Ruminjo (USA), Sayeba Akhter (Bengladesh) • Mohamed Jalloh (Sénégal) 20' L'utilisation du HINARI/PUBMed pour les informations fondées sur des preuves concernant la fistule obstétricale • Pierre Marie Tebeu - Sinan Khaddaj - Joseph Nelson Fomulu - Luc de Bernis - Anderson Sama Doh - Charles Henry Rochat (10') Facteurs de risque de la fistule obstétricale: une revue clinique • Vera Frajzyngier (EngenderHealth) 10' Facteurs influençant les résultats des réparations de fistule dans les pays en développement: une revue systematique de la littérature • Mulu Muleta (Ethiopie) Déterminants socio-demographique de la fistule obstétricale • Luc de Bernis (UNFPA) 10' Quelles informations stratégiques pour la FO? • Table ronde (30'): Perspectives dans la recherche en FO

7/12/2010			
08:00		**Registration**	
08:00 13:00	Room A	**Network of Midwives in the Prevention of Obstetric Fistula**	**Chairs :** Mme Ndeye Mareme Fall (ANSFE, Senegal) - Laurence Monteiro (Benin) - Sebastiana Diatta (DSR, MSP, Senegal)
09:00 13:00	Course 1 : Room B	**VVF surgical tips**	**Chairs:** Mamadou Bobo Diallo (Guinee) - Steve Arrowsmith (USA) - Papa Ahmed Fall (Senegal) • Mamadou Bobo Diallo 10' Introduction • Oumarou Ganda Sanda (Niger) Diagnosis et Evaluation • Kalilou Ouattara (Mali) Classifications • Serigne Magueye Gueye (Senegal) Principles of VVF surgery • Theobald Hategekimana (Rwanda) Management of simple VVF • Steve Arrowsmith (USA) Management of complex VVF • Igor Vaz (Mozambique) Pelvis reconstruction for complex VVF
08 :00 13 :00	Course 2 : Room C	**Urodynamics Workshop**	**Faculty :** Paul Abrams (Bristol, UK) - Sherif Mourad (Cairo, Egypt) - Jeanne Diaw (Senegal) • Paul Abrams (UK) 15' Introduction • Sherif Mourad (Egypt) 15' Voiding diaries Sherif Mourad, Paul Abrams (UK) 60' An Overview of Urodynamics • Sherif Mourad (Egypt) 60' Stress incontinence and OAB Coffee Break (30') • Paul Abrams (UK) 30' Interpretation of Results • Sherif Mourad (Egypt) 30' Writing a report • JJ Diaw - Sherif Mourad - Paul Abrams (60') Case Presentations
14:30 16:00		**Oral session 1**	**Chairs:** Alain Khassim Ndoye (Senegal) - Ambaye Wolde Michael (Ethiopia) - Dr John Mulbah (Liberia) • Amir Yola (Nigeria) Evolution of VVF repair services in Kano state : a 20-year success story • Sunday Adeoye (Nigeria) Micronutrient levels among vesico-vaginal fistula clients in northern Nigeria • Sunday Adeoye (Nigeria) Vitamin levels among vesicovaginal fistula clients in northern Nigeria • Mwangi Judy (Kenya) How accessible are maternal health services to health care providers? Perspectives from four AMRF safe motherhood projects sites • Raheela Mohsin (Pakistan) Prevalence of urinary incontinence and associated factors with impact on women's life in rural Pakistan • Stephen Mutiso (Kenya) The impact of treatment on quality of life in obstetrical fistula patients at Kisii • Khalid Lawal (Nigeria) Management of uretero-vaginal fistula in a rural hospital in Northern Nigeria • Igor Vaz (Mozambique) Neovagina in complex obstetric fistulas

SCIENTIFIC PROGRAM

16 :00 – 16:30 Coffee Break			
16 :30 17:40		**Oral session 2**	**Chairs :** George Fowlis (The Gambia/UK) - Claude Dumurgier (France) - Timothée Kambou (Burkina Faso) • Frank Rubabinda Asiimwe (East Africa) Penn pouch urinary diversion and the Mitrofanoff appendicular continence echanism in obstetrical fistula patient management • Sunday Adeoye (Nigeria) Assessment of UTI among women with vesico-vaginal fistula in South-East Nigeria • Sunday Adeoye (Nigeria) Profile of fistula survivors with childbirth and unrepaired VVF in southeastern Nigeria • Joslyn Meier (EngenderHealth) *Discussion : 10'*
17:40 18:00		**Report of the IOFWG 2010**	Gillian Slinger (UNFPA)
18:00 19:00		**Opening Ceremony**	• Pr Serigne Magueye Gueye - Chairman of the LOC (5') • Dr Kees Waaldijk - President of the ISOFS (10') • Rose Gakuba - UNFPA Country Rep (10') • Keynote (15') -Gillian Slinger (UNFPA New York) Global Campaign to End Fistula : progress and perspectives •- Official opening remarks (20')
19 :00 – 20:00 Welcome Reception			
8/12/2010			
08:00		**Registration**	
08:00 09:30		**Oral session 3**	**Chairs : Mamadou Bâ (Senegal) - Oladosu Ogengbede (Nigeria) - René Hodonou (Benin)** • Amir Yola (Kano, Nigeria) Yankan Gishri Cut as cause of VVF • Edward Stanford Obstetric fistula at the General referral hospital of Panzi, Bukavu, DRC : a retrospective review of 215 patients • Ludovic Falandry (Gabon / France) Treatment of post-obstetrical urethral damage • Sita Millimono (EngenderHealth) Prevention and management of obstetric and traumatic fistulae • Richard Manning (Afghanistan) Challenges in treating OF in a developing nation • Gordon Williams The value of preoperative abdominal ultrasound in patients with an obstetric fistula • Selashi Legessie Fentaw Adult Non-Formal Education in Rehabilitation and Reintegration of Fistula Victims • Gordon Williams "Superbugs" and Fistula Patients: What should we do?
09 :30 09 :50		**FIGO Lecture**	•- Dr. Suzy Elneil Recent advances in urogynecology
09:50 10:10		**PAUSA Lecture**	• Khalilou Ouattara Reflections on the classification of « African » OF
10:10 10:55		**Report of the ICUD 2010 on VVF**	**Chairs:** Paul Abrams (UK), Serigne Gueye (Senegal) **Panel :** Mulu Muleta (Ethiopia), Suzy ElNeil (UK), Rahmat Muhamad (Nigeria), **Reporters:** Dirk de Ridder (Belgium), Sherif Mourad (Ethiopia), Alice Emasu (Uganda)

10 :55 – 11 :05 Coffee Break			
11:05 12:35	Roundtable 1	**Prevention and early management**	**Chairs:** Kees Waaldijk (Nigeria) - Alice Emasu (Uganda) - René Darate (Benin) • Anders Seim (Norway) 10’
12:35 13:00			
13 :00 – 14 :30 Lunch			
14:30 16:00	Roundtable 2	**Patient outreach–support and social reintegration**	**Chairs:** Rose Gakuba (UNFPA) - Sayeba Akhter (Bangladesh) - Kate Grant (USA) • Papa N’diaye, Ndèye Astou Badiane, Anta Tall Dia, Serigne Magueye Gueye (Senegal) 10’ Path of women living with OF in Senegal • Khady Sy Ba (Mauritania) 10’ The role of civil society in OF outreach • Dr Aida Tall (DSR, MSP, Senegal) 10’ The “Bajenu Gox” **Program : A** community-based strategy for fistula outreach • Joan Kabayambi (Uganda), Justus Baragelne (Uganda) 10’ Percieved causes and burden of OF and coping mechanisms of women attending fistula clinic in Mulago Hospital, Uganda •Pierre Marie Tebeu, Luc de Bernis, Laurent Bolsrond, Alain Le Duc, Achille Aurèle Mbassi, - Charles Henry Rochat (10’) Knowledge, attitude and perception about obstetric fistula by Cameroonian women, A clinical survey conducted in Maroua, the capital of far north province of Cameroon • Anne Caroline Benski, G Stancanelli, Charles Henry Rochat (10’) Efficacy of a multidisciplinary strategy for obstetric fistula management: Tanguleta Model in Benin • Dr Mizanur Rahman – Dr Sayeba Akhter Fistula rehabilitation and reintegration program in Bangladesh
16 :00 16 :20		**Special Guest lecture**	• Abdelatif Bencherkroun (Morocco) Continent urinary diversion in severe VVF
16 :20 – 16 :30 Coffee Break			
16 :30 16:50		**Special Guest Lecture**	- **Alain Le Duc (France)** Continence mechanisms in women
16 :50 18:00	Roundtable 3	**Management of complications of VVF**	**Présidents :** Alain Le Duc (France), Gordon Williams (Ethiopie), Cheickna Sylla (Sénégal), Steve Arrowsmith (USA) 10’ Multi-résistance bactérienne aux médicaments et la patiente atteinte de FO • Jérome Blanchot (France) 10’Incontinence après FVV • Ludovic Falandry 10’ L’incontinence résiduelle des urines après fermeture de fistule obstétricale • Cecile Haspels (Netherlands) L’incontinence urinaire et fécale postopératoire après la fermeture de FVV/FRV • Discussion : 20 ‘
18 :00 – 19 :00 ISOFS General Assembly			
20 :00 23 :00	**Gala Dinner**		**Venue: Swimming Pool, Hôtel des Almadies**

SCIENTIFIC PROGRAM

9/12/2010			
08:00		**Registration**	
08:00 09:30		**Oral session 4**	**Présidents :** Kalilou Ouattara (Mali), Ludovic Falandry (Gabon), Khisa Wakasiaka (Kenya) • Yahya Ould Tfeil (Mauritania) 10' Management of VVF in Nouakchott: 50 cases • Habtemariam Tekle (Ethiopia) 10' A Retrospective Analysis of 315 Cases of Rectovaginal Fistulae • Habtemariam Tekle (Ethiopia) 10' Third and Fourth degree perineal tears, their presentation, aetiology and management • Mulu Teka (Ethiopia) 10' What is required to improve access to health services in rural Ethiopia? A community based study • Mark Barone (EngenderHealth) 10' Facility-level predictors of urinary fistula repair outcomes • Molly Melching (Tostan, Senegal) Community and Women's Empowerment to Prevent Harmful Traditional Practices and Fistula • Luc de Bernis (UNFPA) 10' Why quality of OF repair matters - Discussion : 10'
09 :30 09 :50		**FASULF Lecture**	• Beatrice Cuzin (France) VVF in Africa: The current state of affaires and issues surrounding pulic health and humanitarian aid
09:50 10:10		**SIU Lecture**	• Serigne Magueye Gueye (Senegal) Global perspectives in fistula care in the developing world
10 :10 – 10 :20 Coffee Break			
10:20 13:00	Roundtable 4	**Training**	**Chairs:** Hamid Rushwan (FIGO), Luc de Bernis (UNFPA), • Pr Oumarou Ganda Sanda (Niger) 15' The Francophone African Experience in Niger • Pr Oladosu Ogengbede (Nigeria) 15' The Anglophone African Experience in Nigeria • Pr Sayeba Akhter (Bangladesh) 15' The Asian Experience • TBA 15' The Sudanese Experience • Joseph Ruminjo - Isaac Ashwal (Engender Health) 15' An Overview of Training Models • Charles-Henri Rochat (GFMER-Switzerland) 15' Web-based Database Systems • Pr Gordon Williams (Ethiopie) 20' Evaluation chirurgicale dans la formation au traitement de la fistule • Dr Sohier Elneil (UK) 20' Le concept du manuel de formation basée sur les compétences • Conclusion: 15'
13 :00 – 14 :30 Déjeuner			
14:30 15:40	**Oral session 4**	**Surgical outreach /Campagne chirurgicales**	**Chairs :** César Akpo (Bénin), Tom Raassen (Kenya), Jean Marie Colas (France) • Justus Kafungo Barageine (Uganda) 10' VVF Surgical Camp Outreaches the way to manage the VVF Patient Backlog : Experience of Mulago VVF Unit • Tamou Blo, Igace d'Oliveira, René Daraté, René Hodonou, Charles Henri Rochat, Serigne Magueye Gueye, Akpo Cesar (10') Obstetrical Fistula repair training in Benin • Kalidou Ouattara (Mali) 10' Assessment of national and subregional obstetric fistula outreach campaigns • Issa Labou, El hadj Ousseynou Faye, Sogo Millogo, Kalodou Konté, Mouhamed Jalloh, Madina Ndoye, Jean Charles Moreau, Serigne Magueye Gueye (10') Experience of fistula outreach activities in Senegal • Filiberto Zattoni (Italy) 10' Experience of fistula outreach in Ngosi Burundi • Valentin Vedandi, Henry, Benoit Management of OF at Regionl hospital of Abeche, Region of Ouadai, chad • Discussion 10'

15:40 17:00	Roundtable 5	**Research in OF**	**Chairs :** Mulu Muleta (Ethiopia)- Steve Arrowsmith (USA) - Joseph Ruminjo (USA) - Sayeba Akhter (Bangladesh) • Mohamed Jalloh (Senegal) 20' Use of HINARI/PUBMed for Evidence-based information on Obstetrical Fistula • Pierre Marie Tebeu , Sinan Khaddaj, Joseph Nelson Fomulu, Luc de Bernis, Anderson Sama Doh, Charles Henry Rochat (10') Risk Factors of obstetric fistula: a clinical review • Vera Frajzyngier (EngenderHealth) 10' Factors influencing fistula repair outcomes in developing country settings : a systematic review of the literature • Mulu Muleta (Ethiopia) 10' Socio-demographic determinants of obstetric fistula • Luc de Bernis (UNFPA) 10' What strategic information for OF? • Panel discussion (20'): gaps in research around obstetric Fistula
17:00 17:30		**Take home messages and way forward**	Closing remarks

ABSTRACTS

Evolution of VVF Repair Services in Kano State : A 20 YRS SUCCESS STORY

L'évolution des services de traitement des FVV dans l'Etat de Kano: Une histoire réussie au bout de 20 ans

Amir YOLA, Nigeria

Background

Kano state is one of the regions with the high number of VVF cases in northern Nigeria with estimated incidence of 3:1000 deliveries. Generally vvf repair services in Kano dated back to 1960's but a comprehensive documentation started in the late 80's.

Objective

This paper presents a 20yrs review of the evaluation of vvf repair services in Kano State in terms of Facility, Services and Manpower development.

The VVF center located at Murtala Muhammad Specialist Hospital is a 40 bed capacity ward with a functioning operating theater and staff strength of 22 including three surgeons. The annual clinic attendance is above 1000 patients and the number of operated cases over 500 annually.

The center came into existence in 1990 when Dr Kees flag off VVF repair services through the effort of the state government and some women organizations. Now two other doctors trained by him are also performing surgery in the center at different levels with an average operation time of30 minutes for fresh cases and 60minutes in case of a previously operated patient. The center has a record of success rate of 98% for fresh cases and 75% for mutilated/previously operated cases.

Trends in the development and efficiency of VVF repair services are discussed together with the challenges and the future prospects of the services in Northern Nigeria.

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Micronutrient Levels among Vesico-Vaginal Fistula Clients in Northern Nigeria

Taux de micronutriments parmi des patientes atteintes de VVF dans le nord du Nigéria

Sunday-Adeoye, National Fistula Centre Abakaliki, Ebonyi State, Nigeria

Background

Micronutrients are required by the body in small amounts and they play leading roles in the functions of enzymes, hormones and other substances that help to regulate growth, development. Adequate intake is essential during girl child development and other periods of rapid growth, pregnancy and lactation. The lack of these essential micronutrients may affect the development of the bones, individual lacking zinc may develop osteoporosis or slow bone growth which can result in short stature.

Objective

This study was conducted to provide baseline data on micronutrients levels among VVF clients.

Method

Samples were collected from 67 VVF Clients undergoing treatments at the Evangel Hospital, Jos and the controls were 30 non pregnant but parous women of similar social status who were willing to participate in the study. Informed consent was

obtained from each of the participants. Serum levels of zinc, lead, copper, manganese, and iron were determined using the Buck Scientific Atomic Absorption Emission Spectrophotometer. (AAS)

Results

The mean values of the minerals were similar for both clients and control groups except for zinc and lead where there was a statistically significant ($p<0.05$) difference. The mean value of zinc in the VVF client was curiously double the value in the control. The mean value of lead in the VVF clients was thrice the value of the control. Furthermore, the level of iron in both groups was higher than the reference values reported in the literature. These higher levels of lead, iron and manganese in fistula patients may suggest contamination which may possibly be through water or food.

Conclusion

The higher mean value of zinc in fistula clients is an unexpected finding that calls for another study using a larger sample size and the higher level of lead among the clients is a source of concern.

Vitamin levels among, Vesico-Vaginal Fistula clients in Northern Nigeria

Taux de vitamines parmi des patientes atteintes de VVF dans le nord du Nigéria

Sunday-Adeoye, National Fistula Centre Abakaliki, Ebonyi State, Nigeria

Background

The social burden of VVF results from incontinence and childlessness and may lead to marital breakdown, eventually divorce, and social excommunication. All these factors combine to make these fistula clients a highly vulnerable group in the society with low economic power and low social class. Among people of low socioeconomic class like VVF patients, the expected prevalent form of malnutrition is the deficiency type and these could range from deficiency of one nutrient to general deficiency of several nutrients.

Objectives

This study was conducted to provide baseline data on micronutrients levels among VVF clients, and to establish their socio-demographic characteristics. Samples were collected from 67 VVF Clients undergoing treatments at the Evangel Hospital, Jos and the controls were 30 non pregnant but parous women of similar social status who were willing to participate. Informed consent was obtained from each of the participants. Two fat soluble vitamins, vitamin A and E were assayed for using spectrophotomeric method.

Results

The mean values of vitamin A and E were significantly ($P<0.05$) lower than the reported values in the literature and this is consistent with the view that vitamin levels may be lower in people of lower social class.

Conclusion: This study calls for a greater research interest in micronutrient values for vulnerable groups and the normal Nigerian population. It supports the earlier assumption that vitamin levels may be lower in people of low socio-economic group.

How accessible are maternal health services to health care providers? Perspectives from four AMREF Safe Motherhood project sites, Kenya

Quelle est l'accessibilité des services de santé maternelle pour le personnel de santé? Perspectives venant de quatre sites du projet de maternité sans risque de l'AMRF

Mwangi Judy, Outreach Program, AMREF in Kenya

Background

The health care response in Kenya relies heavily on health care workers; however due to social-economic challenges affecting the general population, the health care workers are just as vulnerable to poor health care access and utilisation as they have restricted access to treatment, care, and support services.

Objective

To obtain insight into health care practices among health care workers (Nurses/Clinical Officers) and associated deterrents in access/utilization of the same in order to elicit implications for the safe motherhood project and the health care system in general.

Methods

A cross-sectional descriptive study based on 101 health care providers collected from all the public health care facilities in four districts in Eastern Province in 2009. A self administered structured tool was used to obtain data, while secondary data was collated from various project documents to obtain background information relevant to the study.

Findings

The nearest health facility was less than five kilometers for most workers (80%). Unskilled birth attendance was 32%, ANC attendance; 86%, first ANC was at above the recommended 16 weeks in 76%, contraceptives use; 53%, while absence of spousal awareness and support in family planning was, 33% and 40% respectively. Occurrence of unplanned pregnancy was reported in 36% of the respondents. Obstetric fistula occurrence, treatment and prevention awareness was about 60% on each count.

Conclusion

Despite that the health care providers have better social economic markers than the general community in the area; they are still constrained in accessing health services. There is need to focus on health care targeted to these workers in order for them to effectively act as change agents in maternal health care practices.

Prevalence of urinary incontinence and associated factors with impact on women's life in rural Pakistan

Prévalence de l'incontinence urinaire et des facteurs associés ayant un impact sur la vie des femmes en milieu rural au Pakistan

Raheela Mohsin, Aga Khan University Hospital, Pakistan

Background

Urinary incontinence (UI) is a major worldwide public health problem affecting young and as well as older across different cultures and races. Prevalence studies in general population are rare and the impact of urinary incontinence on quality of life has not been addressed in developing countries.

Objectives

The primary aim of the study was to ascertain the prevalence and associated factors of UI in women in rural Pakistan. The secondary aim was to assess their effects on quality of life.

Methods

In a cross-sectional multistage random sampling study an interview based structured questionnaire was used to collect data, followed and verified by physical examination. Subjects were women aged 15-60 years living in the catchment population of the two public health centers over 4 months. The main outcome measures were urinary incontinence and variables that affecting life such as leakage bothers; leakage interferes in life and doctor consulting.

Results

The prevalence of UI was found 15.4%including 6.89% of total Urinary Incontinence (VVF). Cases 3.6% identified along with uterine-prolepses. The majority of cases 83.7% of UI were found in women of the age between 31-35 years and the highest (39.5%) were in women with Para 1-5 children. Cases 15% were with UI were unmarried and overall 80% cases never bothered to get check-up by a doctor.

Conclusion

Our findings have shown that UI is a major health problem in women in rural Pakistan. Further investigation is required with special focus on unmarried women. Appropriate measures are required to prevent and treat disabling condition meeting the health needs of women.

The impact of treatment on quality of life in obstetric fistula patients at Kisii, Kenya

L'impact de traitement sur la qualité de vie des patientes porteuses de fistules obstétricales à Kisii

Stephen Mutiso , Obstetrician and Gynecologist/Fistula patients at Kisii, Kenya

Background

Involuntary loss of urine has multiple implications for the sufferer. Incontinence has been noted to be a major barrier to social interests, entertainment, or physical recreation. Ample evidence suggests that urinary incontinence affects a person's quality of life. However, little formative data has been gathered in the context of obstetric fistula patients.

Objective

To assess quality of life in obstetric fistula patients at admission and six months after treatment.

Method

This was a prospective analytical study focusing on obstetric patients treated in Kisii Level Five Hospital in Nyanza Region, Kenya in November 2009. The King Health Questionnaire (KHQ) psychometric tool for measuring quality of life was administered to all consenting patients on admission and at six months follow-up. Higher scores denoted lower QOL. The t-test measure was utilized to compare means in the KHQ dimensions.

Results

40 consenting women were interviewed and follow up after six months. About three quarters (74%) had VVF, while the rest had RVF (23.7%) and both RVF/VVF (2.3%). The mean age was 32 years (range=15-70). 27.3% had no living children, while about two thirds were married (66.1%). Repeat surgery cases constituted 14%. The fistula closure rate was 88%, with 20% stress incontinence six months post repair. The KHQ outcomes before and six months post repair showed significantly reduced differences in means in all quality of life indicators notably, emotions(mean diff 56; $p<0.000$; 95% CI:34-78) role limitation (mean diff 49; $p<0.000$; 95%CI:31-68) and physical limitations (mean diff 56; $p<0.000$; 95%CI:37-75).

Conclusion

OF treatment was found to improve quality of life in all dimensions. We recommend early repair to reduce the time span the women live with the disability and subsequent lost life-years. We need to use treatment which is more comprehensive encompassing surgery, physiotherapy, psychosocial support

Management of uretero-vaginal fistula in a rural hospital in northern Nigeria

Prise en charge des fistules urétéro-vaginales dans un hopital rural dans le nord du Nigéria

Khalid Lawal, Ahmadu Bello University Teaching Hospital, Zaria, Nigeria.

Background

In developed countries, most uretero-vaginal fistulas are secondary to unrecognized injuries of the urethra sustained during gynecologic procedures, the most common being hysterectomy (vaginal, abdominal, laparoscopic). On the other hand, in developing countries like Nigeria, caesarian sections and caesarian hysterectomies are the leading causes of urethra injury leading to uretero-vaginal fistula. Over a period of 4 years (2007 –2010), we managed a total of thirty three (33) women with uretero-vaginal fistula, complicating surgery, in a Vesico-Vaginal Fistula (VVF) Centre at a District General Hospital in Northern Nigeria. Thirty two (32) patients had emergency caesarian section, while only one patient had a total abdominal hysterectomy. Majority of the patients were indigent and have been leaking urine for over three months.

Method

A retrospective study of 33 women managed with leakage of urine despite the urge to micturate. Diagnosis was based on simple and cheap 3-swab dye test coupled with abdomino-pelvic ultrasound scan. All patients had open surgery; transvesical re-implantation (27 patients), re-implantation with psoas hitch (4 patients), substitution ureteroplasty with appendix (1 patient) and nephrectomy (1 patient). The duration of post operative stay was about 3 to 6 weeks..

Result

All patients were dry after removal of ureteric stent and urethral catheter. Wound infection was recorded in 2 patients. Follow up was for upward of three months.

Conclusion

This report illustrates the success of simple diagnostic technique and management of uretero-vaginal fistula in a resource-constrained rural district hospital.

Neovagina in complex obstetric fistulas

Néo-vagin edans les fistules obstétricales complexes

Igor Vaz, Urology Department, Maputo Central Hospital, Mozambique

Introduction

Sexuality and child bearing is the main issue in African community. After a desperate situation of having a stillbirth, after the first pregnancy, these young ladies have a vésico-vaginal fistula, loose friends and family, outcast from the society, and do not return to a normal life, get married or have sex. Cure rate of vesico-vaginal fistulas is achieved in near 98% in good hands but there are no reports on sexual activity after VVF surgery. Since 1996 we begun to do neo vagina plasty from labia minor, and from skin flaps. Results was good at the beginning but months later most of these ladies have complained of painful sex or scarred and obstructed vagina. In 2002 with some experience from congenital malformations in vaginal agenesis and successful surgeries in neo vagina, we began to do the sigmoid neo-vagina in our VVF patients.

Materials and methods:

A 10 years experience was studied retrospectively and 16 skin flaps vagino-plasties were compared with 20 cases where we found much less complications than in cases using bowel for neo-vagina. A fallow up is done in the consultation room for one year. Short vagina, dyspareunia, and psicogycal trauma are the

main reason for stop doing sex in the VVF patient.
Results: 80 % of our patients with bowel neo vagina return to sex life compared with less that 20% after a skin flap vaginoplasty. Complications on the bowel neo-vagina was : Small fibrotic ring solved with dilatation in some cases , one stenosis from scar tissues surrounding the neo vagina and a complete necrosis on 7th day. Patients that underwent vaginoplasty with skin flaps and labia had more fibrotic complications.
Conclusions: Abdominal or combine approach is normally needed for very complex cases in VVF fistula repair, bowell seems to be usefull and with better results

Penn Pouch urinary Diversion and the Mitrofanoff appendicular continence mechanism in obstetric fistula patient management

Diversion urinaire par la technique "Penn Pouch" et Appendicovésicostomie de Mitrofanoff dans la prise en charge des patientes atteintes de fistules obstétricales

Frank Rubabinda Asiimwe, Kagando Hospital, Uganda, East Africa

Background

In about 15% of all Obstetric fistula patients seen, there is extensive urethral, periurethral, bladder neck and perivesicle tissue damage. Even in the best surgical hands, 2-5% of vvf patients fall in the extreme category of this type of damage and cannot have full/any continence restored.
Many fistula surgeons therefore, offer urinary diversion of different forms to restore control of voiding. Most diversions involve mixing of the urine and faeces, which has important disadvantages such as nocturnal incontinence, ascending urinary tract infection etc.
The Penn pouch was first described in 1980. The right hemicolon is mobilized off the terminal ileum and transverse colon and turned into a pouch into which the ureters are reimplanted. The appendix is reversed and exteriorized to the anterior abdominal wall to give a catheterizable continent conduit – the mitrofanoff. The urine and the faeces therefore remain separate.

Objective

To perform urinary diversion that provides urinary continence and avoids troublesome faecal incontinence as a result of the diversion.

Methodology

In Kagando Hospital, 18 Penn pouches have been performed since 1997. 8 Case done since 2008 are being reported on in this study, case notes of patients operated on before 2010 were reviewed. A prospective assessment and follow up of patients operated since 2010 was done.

Results

Of the 10 cases reviewed in this study, all were dry & continent. With the exception of one 60 year old who died of Malaria 3 months after the diversion, the rest of the patients have had total restoration of control of their physiological and social functions.

Conclusions

The Penn pouch is an excellent urinary diversion procedure which gives the woman full continence and control of their voiding independent of their rectal function. These women were rehabilitated, restored to a full social livelihood.

Recommendation

It is recommend that Penn pouch be the preferred diversion procedure for all patients with inoperable fistulae. It is the only procedure recommended for women with inoperable fistula and have poor anal sphincters.

Key words

Obstetric fistula urinary diversion surgery; Penn Pouch and Mitrofanoff continence Mechanism

Assessment of Urinary Tract Infection among women with Vesico-vaginal Fistula in South-East Nigeria

Evaluation des IVU parmi des femmes porteuses de fistules vésico-vaginales dans le sud-est du Nigéria

Sunday-Adeoye, National Fistila Centre, Abakaliki, Ebonyi State, Nigeria

Background

Vesico-vaginal fistula (VVF) is a major gynaecological and public health concern in most developing countries including Nigeria. Due to the direct pathological communication between the urinary bladder and the vagina, possible complications arising from urinary tract infection (UTI) merits consideration.

Method

In this cross-sectional study an assessment of UTI was conducted among HIV negative women diagnosed with VVF at the National VVF Centre Abakaliki Nigeria using pipette specimen of urine and standard microbiological technique. Haematological and anthropometric parameters were also assessed and related to UTI. Informed consent was obtained from the 109 clients.

Results

The prevalence rate of UTI was 76.1%. The highest prevalence of UTI was found among individuals aged 21-30years (90.3%), those with more than 7 deliveries (85.0%) and those whose labour duration lasted above 24hours (76.7%). The rate of UTI was least among women with less than one year of urine leakage (54.5%), the UTI rate ranged from 62.5% to 89.6% for those with VVF for more than one year. The prevalence was highest among patients with large fistula (85.7%), circumferential fistula (87.5%), and juxta urethral fistula (87.5%). The prevalence was highest in women of blood group AB (100%) and least in blood group O. UTI rate was higher among women whose heights were less than 1.53m (80.8%) and those whose weights were less than 51kilogram (76.0%). Six different bacteria species and Candida albicans were isolated from the clients. Among the bacterial isolated, the highest were Escherichia coli (41.9%), Proteus species (20.9%), and Klebsiella species (17.4%). The bacterial isolates were resistance to many of the antibiotics assessed but were susceptible to gentamycin, ciprofloxacin, ofloxacin, ceftriaxone and Pefloxacin.

Conclusion

Results showed that the prevalence of UTI among VVF patients is rather high and should probably not be neglected in the management of VVF patients.

Profile of Fistula Survivors with childbirth and unrepaired Vésico-Vaginal Fistula in SouthEastern Nigeria

Profil des femmes porteuses de fistule accouchant avec les FVV non réparées dans le Sud-Est du Nigéria

Sunday-Adeoye, National Fistula Centre, Abakaliki, Ebonyi State, Nigeria

Background

Vesico-vaginal fistula (VVF) is a disease often associated with stigma and ostracization in some communities with attendant marital disharmony, secondary amenorrhoea, infertility and childlessness .

Objective

This study seeks to review the profile of fistula survivors who achieved childbirth in spite of unrepaired VVF.

Material and Method

Cross-sectional study based on an interviewer administered questionnaire involving 282 clients with unrepaired VVF at the South East Fistula Centre, Abakaliki, Nigeria.

Results

Thirty percent had achieved childbirth in the face of unrepaired VVF as compared with the remaining unrepaired 197 clients. The mean age of the childbirth group was 42.9±9.4years and 36.9years±12.6 for the remaining clients. The mean height and weight for the child birth group was 150.7cm±108 and 47.7kg± 6.72, respectively and 151.8cm±109 and 49.4.kg ± 8.3 respectively for height and weight for the remaining population. Eighty-eight percent of the childbirth group was still menstruating as compared with 58.6% of the other group. Thirty-eight percent had one delivery after development of VVF and 42.4% had 2-4 deliveries. Among the childbirth group, 24.7% of them had no living child while among the outstanding 197 clients studied, 47.2% had no living child. Eighty-eight percent of the child birth group subsequently had vaginal delivery. The predominant anatomic locations of the fistula were juxta-cervical and sub-urethral.

Conclusion

This study highlights the fact that clients with unrepaired VVF may still be sexually active and even achieve child birth. It equally supports the view that subsequent vaginal birth may still be possible in some VVF clients presumably with a smaller fetus.

Mapping Fistula Services in Uganda Using Geographic Information System (GIS) Techniques

Cartographie des services de traitement de fistule en Uganda à travers les systèmes d'information géographique (SIG)

Joslyn E. Meier, Fistula Care/Engender Health, Uganda

Background

Approximately 2.6% of Ugandan women have experienced the symptoms of obstetric fistula. In Uganda, the Ministry of Health (MOH) coordinates provision of and support for fistula services by local and international stakeholders. However there is no centralized database of who is doing what, where. Thus challenges ensue in coordinating services. Therefore, Fistula Care/ Engender Health initiated a process of mapping fistula services in Uganda using GIS techniques.

Objective

To create a map of fistula services in Uganda, thereby enabling the MOH and other fistula stakeholders to better understand what fistula services are available and where.

Methodology

We compiled data from several sources on hospitals providing fistula services, fistula surgeons and their skill level, and supporting organizations and their coverage areas. Fistula surgeons were interviewed by phone and asked to assess their skill level in fistula repair. The data was entered into a database and mapped using GIS techniques. A draft map was presented to the MOH Fistula Technical Working Group (FTWG). A Fistula Mapping Sub-Committee was formed and tasked with reviewing, contributing additional data to, and verifying the maps. The Sub-Committee was chaired by the MOH, and included representatives of all major fistula stakeholders in Uganda.

Results

Two final maps were developed. The first map shows where fistula treatment services are offered, whether the services are routine or episodic, and fistula surgeon's skill level and activity status (visiting or active). A second map shows where fistula reintegration services are offered and where fistula services are supported by development partners.

Conclusion

The active involvement of all stakeholders enabled the creation of a comprehensive map of fistula services, surgeons and development partner support. These maps will assist the MOH to better coordinate fistula services in Uganda. The maps can also be used to refer fistula clients, allocate resources for fistula services, and for decision making by all stakeholders.

Gynecological Fistula in the D. R. Congo
Fistules gynécologiques en RDC

Denis Mukwege, Congo

Background

Vesico-vaginal fistula (VVF) is a major gynaecological and public health concern in most developing countries including Nigeria. Due to the direct pathological communication between the urinary bladder and the vagina, possible complications arising from urinary tract infection (UTI) merits consideration.

Method

In this cross-sectional study an assessment of UTI was conducted among HIV negative women diagnosed with VVF at the National VVF Centre Abakaliki Nigeria using pipette specimen of urine and standard microbiological technique. Haematological and anthropometric parameters were also assessed and related to UTI. Informed consent was obtained from the 109 clients.

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The prevalence rate of UTI was 76.1%. The highest prevalence of UTI was found among individuals aged 21-30years (90.3%), those with more than 7 deliveries (85.0%) and those whose labour duration lasted above 24hours (76.7%). The rate of UTI was least among women with less than one year of urine leakage (54.5%), the UTI rate ranged from 62.5% to 89.6% for those with VVF for more than one year. The prevalence was highest among patients with large fistula (85.7%), circumferential fistula (87.5%), and juxta urethral fistula (87.5%). The prevalence was highest in women of blood group AB (100%) and least in blood group O. UTI rate was higher among women whose heights were less than 1.53m (80.8%) and those whose weights were less than 51kilogram (76.0%). Six different bacteria species and Candida albicans were isolated from the clients. Among the bacterial isolated, the highest were Escherichia coli (41.9%), Proteus species (20.9%), and Klebsiella species (17.4%). The bacterial isolates were resistance to many of the antibiotics assessed but were susceptible to gentamycin, ciprofloxacin, ofloxacin, ceftriaxone and Pefloxacin.

Conclusion

Results showed that the prevalence of UTI among VVF patients is rather high and should probably not be neglected in the management of VVF patients.

Profile of Fistula Survivors with childbirth and unrepaired Vésico-Vaginal Fistula in SouthEastern Nigeria
Profil des femmes porteuses de fistule accouchant avec les FVV non réparées dans le Sud-Est du Nigéria

Sunday-Adeoye, National Fistula Centre, Abakaliki, Ebonyi State, Nigeria

Aperçu historique

la fistule gynécologique est un problème international de la santé qui afflige beaucoup de femmes dans les pays pauvres d'Afrique et le sud de l'Asie. Bien que l'ampleur ne soit pas connue on croit que c'est un grand problème dans la RDC. Les données préliminaires de l'hôpital de la RDC montrent que la césarienne compliquée et la violence sexuelle sont des causes importantes de la fistule, en plus d'un travail obstrué. Cette présentation clinique dévie les résultats rapportés des recherches faites dans d'autres pays sub-saharien d'Afrique. Il n'y a presque pas des recherches académiques déjà faites sur la fistule en RDC.

Objectif

l'objectif était de mettre sur pied la connaissance des caractéristiques de la fistule gynécologique dans l'est de la RDC en terme de l'étiologie de la fistule, la démographie des patientes les aléas de la fistule et les prédictions des conséquences de la chirurgie.

Méthodologie

une analyse rétrospective des fiches de l'hôpital de 604 patientes consécutives qui ont reçu le traitement des fistules gynécologiques à un centre de référence de fistule dans l'Est de la RDC. pendant une période de 24 mois.

Résultats

82% de femmes on eu la fistule à cause d'un travail obstrué et 17% après une mauvaise administration médicale dont 70% impliqué la section de la césarienne. 5 cas (0, 9%) étaient causés par la violence sexuelle.

L'âge moyenne de fistuleuses était de 23 ans et la taille moyenne était de 150 cm. 17% de femmes étaient divorcées, 41% étaient des primipares et 34% étaient des multipares avec quatre ou plus. La majorité passer deux jours ou plus dans le travail dans l'indexe d'accouchement et 90% d'enfants étaient des mort-nés. 42% accouchaient par césarienne et 85% de césariennes étaient faites sur des enfants morts. Les femmes avec fistule dû à un travail obstrué passaient la moyenne de trois ans avant de se faire soigner alors qu'une année pour les femmes avec la fistule iatrogène.31% de femmes avaient des réparations précédentes échouées. La réussite générale était de 87%, 16% de femmes sont restées incontinentes et 13% échouées. L'échec était significativement associé aux réparations précédentes, une quantité de fibrose et la localisation de la fistule. La fistule iatrogène avait une bonne conséquence pour la plupart de fois expliquée par les qualités de la fistule. Le taux de réussite de la fermeture de la fistule chez les patientes sans chirurgies précédents était de 90,7% avec 11,5% qui restaient incontinente.

Conclusion

le travail obstrué était la cause principale de la fistule. Le grand pourcentage de fistules était causé par une mauvaise administration (erreur) médicale, ce qui indiqu' il y a un besoin d'autres formations et la réglementation des services obstétriques et faire un appel de renforcer de nouveau le rôle des sages femmes dans leur assistance dans les accouchements. La fistule comme conséquence directe du viol est rare.

L'âge à laquelle la fistule se développe était avancé plus que d'autres études dont les résultats peuvent être des indicateurs des accouchements mal assistées et le manque de l'accès aux soins obstétriques d'urgence. Le retard du traitement était aussi long que dans la plus part des études et il y a un besoin d'améliorer la prise de conscience de la fistule et le traitement disponible. Seuls les chirurgiens qualifiés devront réparer la fistule.

Yankan gishiri cut as cause of VVF

Coupure Yankan Gishri comme cause de FVV

Amir YOLA, Nigeria

Introduction`

Contrary to what is obtained in the rest of the world by what is meant FGM, in the HAUSALAND yankan gishiri is the cultural practice where wanzami-a barber or ungozoma a TBA makes a cut in the vagina, and depending on the extent, severity and application of herbs it results in a urinary fistula.

Objectives

This paper presents a three year review of 1372 VVF operated cases in three centers in kano to determine the incidence of yankan gishiri as a cause of vvf.

Design/Method

Post operation documents at Laure, Danbatta and Wudil centers were retrospectively studied to see how many of the VVF patients have had yankan gishiri in their lifetime.

Findings/Results

From June 2007 to May 2010 1372 VVF patients were operated upon by the author/reviewer and it was found that 78(5.68%) of them were due to this cultural practice of yankan gishiri out of which 48(61.53%) were performed by wanzami and 30(38.47%) by ungozoma.

Conclusion

The study revealed that a significant percentage of urinary fistula is caused by a cultural practice of yankan gishiri which can be prevented with awareness creation and adequate mobilization.

Obstetric fistula at the general referral Hospital of Panzi, Bukavu, Democratic Republic of Congo: a retrospective review of 215 patients

Fistule obstétricale à l'hôpital général de référence de Panzi à Bukavu, RDC: une revue rétrospective de 215 patientes

Edward Standford, Congo

Objective

Describe demographics, diagnoses and treatment success of women presenting to the General Referral Hospital of Panzi, Bukavu, Democratic Republic of Congo (DRC) for treatment of obstetric fistula.

Study design

Retrospective chart review of 215 patients evaluated for obstetric fistula from April to December 2009. Demographic, pre-operative physical examination, fistula classification, surgical procedures and follow-up assessment were included.

Results

The majority of patients were from Kalemie, DRC (n=53). Mean (+ SD) age at presentation was 31.14 years +13.22 years and mean age at first delivery was 19.0 years. 85 (40.5%) patients were primiparous. 106 (50.2%) reported fistula development after vaginal delivery, 79 (37.4%) after a cesarean delivery and 13 (6.2%) after a vacuum assisted vaginal delivery (VAVD). Overall, 157 (82.2%) reported at least one prior vaginal delivery and 41.2% of patients reported a prior cesarean. 19 patients reported a history of sexual violence that did not directly lead to fistula formation.

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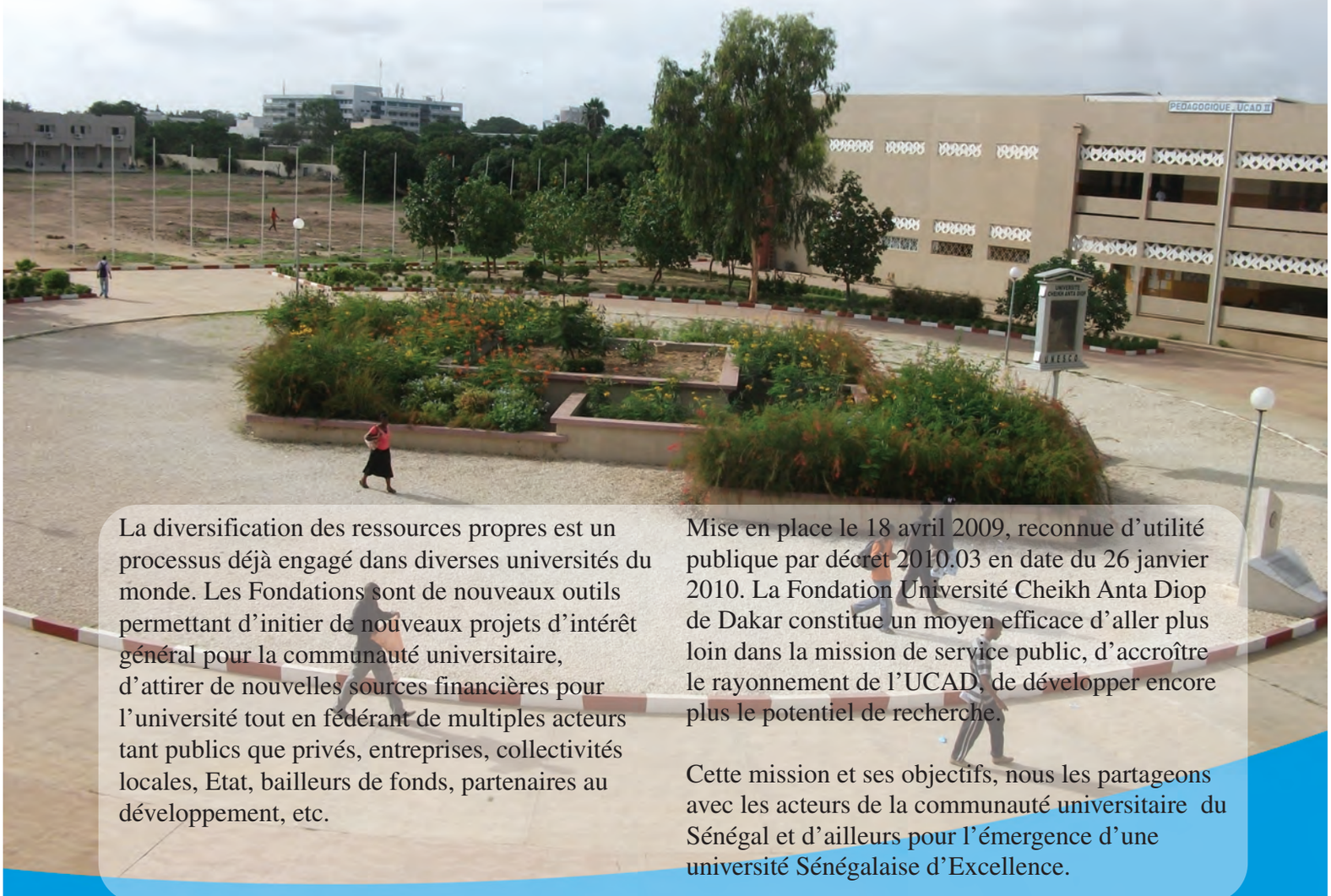

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FORMES et PRÉSENTATIONS : Comprimé pelliculé à 250 mg (blanc) : Étui de 20. Comprimé pelliculé à 500 mg (blanc) : Étuis de 14. Suspension buvable à 4 % : Flacon de 120 ml avec cuillère-mesure de 5 ml. Solution injectable pour perfusion à 0,5 % : Poche souple de 100 ml, boîte de 25. COMPOSITION : Métronidazole (DCI) 500mg/100 ml solution injectable pour perfusion. Excipients : phosphate disodique, acide citrique monohydraté, chlorure de sodium, eau ppi. Teneur en sodium : 0,34 g/poche. Métronidazole (DCI) comprimé, 250 mg, 500 mg Excipients (communs) : amidon de blé, povidone K 30, stéarate de magnésium. Pelliculage : hypromellose, macrogol 20 000. Suspension buvable à 4 % (p c mes) Métronidazole (DCI) benzoate exprimé en métronidazole 125 mg. INDICATIONS : Elles procèdent de l'activité antiparasitaire et antibactérienne du métronidazole et de ses caractéristiques pharmacocinétiques. Elles tiennent compte à la fois des études cliniques auxquelles a donné lieu ce médicament et de sa place dans l'éventail des produits anti-infectieux actuellement disponibles. Elles sont limitées aux infections dues aux germes définis comme sensibles : amibiases; trichomonases urogénitales; vaginites non spécifiques; lambliases; traitement curatif des infections médicochirurgicales à germes anaérobies sensibles; relais des traitements curatifs par voie injectable des infections à germes anaérobies sensibles. Il convient de tenir compte des recommandations officielles concernant l'utilisation appropriée des antibactériens. POSOLOGIE ET MODE D'ADMINISTRATION : Amibiase : Adultes : 1,5 g par jour, en 3 prises. Enfants : 30 à 40 mg/kg/jour, en 3 prises. Dans l'amibiase hépatique, au stade abcédaire, l'évacuation de l'abcès doit être effectuée conjointement au traitement par le métronidazole. La durée du traitement est de sept jours consécutifs. Trichomonase : Chez la femme (urétrites et vaginites à trichomonas), de préférence, traitement mixte de 10 jours comportant : comprimé à 250 mg et suspension buvable : 500 mg par jour par voie orale en deux prises et 1 ovule par jour ; comprimé à 500 mg : traitement à dose unique de 2 g en une seule prise (4 comprimés). Que le partenaire présente ou non des signes cliniques d'infestation à Trichomonas vaginalis, il importe qu'il soit traité concurremment, même en l'absence d'une réponse positive du laboratoire. Chez l'homme (urétrites à trichomonas) : 500 mg par voie orale en deux prises pendant 10 jours. Très exceptionnellement, il peut être nécessaire d'élever à 750 mg ou à 1 g la dose journalière (comprimé à 250 mg et suspension buvable). Lambliase : Adultes : 750 mg à 1 g par jour pendant 5 jours consécutifs. Enfants : 2 à 5 ans : 250 mg/j (suspension buvable) ; 5 à 10 ans : 375 mg/j (suspension buvable et, à partir de 6 ans, pour les comprimés à 250 mg) ; 10 à 15 ans : 500 mg/j. Vaginites non spécifiques : 500 mg 2 fois par jour pendant 7 jours. Un traitement simultané du partenaire doit être pratiqué. Traitement des infections à germes anaérobies (en première intention ou en traitement de relais) : Adultes : 1 à 1,5 g/jour. Enfants : 20 à 30 mg/kg/jour. . Traitement des infections à germes anaérobies : Adultes : 1 à 1,5 g par jour en 2 ou 3 perfusions intraveineuses. Enfants : 20 à 30 mg/kg/jour en 2 ou 3 perfusions intraveineuses. Le relais peut être pris par voie orale, à la même osologie, lorsque l'état du malade le permet. Prophylaxie des infections postopératoires en chirurgie : L'antibioprophylaxie doit être de courte durée, le plus souvent limitée à la période peropératoire, 24 heures parfois, mais jamais plus de 48 heures. Adultes : 30 minutes avant le début de l'intervention, injection intraveineuse d'une dose unique de 1 g. Enfants : 30 minutes avant le début de l'intervention, injection intraveineuse d'une dose unique de 20 à 40 mg/kg. Mode d'administratio : Administration en perfusion veineuselente, à raison d'une poche de 100 ml (500 mg) passée en 30 à 60 minutes. CONTRE-INDICATIONS : Absolues : Hypersensibilité aux imidazolés. Hypersensibilité ou intolérance au gluten, en raison de la présence d'amidon de blé (gluten, pour la forme comprimé). Enfant de moins de 6 ans, en raison de la forme pharmaceutique (pour la forme comprimé). Relatives : Disulfirame ou alcool : cf Interactions. MISES EN GARDE et PRÉCAUTIONS D'EMPLOI : Mises en garde : Éviter les boissons alcoolisées (effet antabuse) : cf Interactions. Interrompre le traitement en cas d'ataxie, de vertiges, de confusion mentale.Tenir compte du risque d'aggravation de l'état neurologique chez les malades atteints d'affections neurologiques centrales et périphériques sévères, chroniques ou évolutives. Suspension buvable : En raison de la présence de saccharose, ce médicament est contre-indiqué en cas d'intolérance au fructose, de syndrome de malabsorption du glucose et du galactose ou de déficit en sucrase-isomaltase. Précautions d'emploi : Aucune suspicion de cancérogénicité n'existe chez l'homme, bien que ce produit se soit révélé carcinogène chez une certaine espèce de souris, mais non chez le rat et le hamster. En cas d'antécédents de troubles hématologiques, de traitement à forte dose et/ou de traitement prolongé, il est recommandé de pratiquer régulièrement des examens sanguins, particulièrement le contrôle de la formule leucocytaire. En cas de leucopénie, l'opportunité de la poursuite du traitement dépend de la gravité de l'infection. En cas de traitement prolongé, surveiller l'apparition de signes évocateurs d'effet indésirable à type de neuropathie centrale ou périphérique (paresthésies, ataxie, vertiges, crises convulsives. Tenir compte, chez les personnes suivant un régime hyposodé strict, de la teneur en sodium (cf Composition). Suspension buvable : Ce médicament contient 40 mg d'alcool par cuillère-mesure. Il est déconseillé chez les patients souffrant de maladie du foie, d'alcoolisme, d'épilepsie, de même que chez les femmes enceintes et les enfants de moins de 12 ans. Tenir compte dans la ration journalière de la teneur en saccharose (cf Composition). INTERACTIONS : Interactions médicamenteuses : Déconseillées : Alcool : effet antabuse (chaleur, rougeurs, vomissements, tachycardie). Éviter la prise de boissons alcoolisées et de médicaments contenant de l'alcool. Disulfirame : bouffées délirantes, état confusionnel. Nécessitant des précautions d'emploi : Anticoagulants oraux : augmentation de l'effet de l'anticoagulant oral et du risque hémorragique par diminution de son métabolisme hépatique. Contrôle plus fréquent du taux de prothrombine et surveillance de l'INR. Adaptation de la posologie de l'anticoagulant oral pendant le traitement par le métronidazole et 8 jours après son arrêt. A prendre en compte : Fluorouracile : augmentation de la toxicité du fluoro-uracile par diminution de sa clairance. Examens paracliniques : Le métronidazole peut immobiliser les tréponèmes et donc faussement positiver un test de Nelson. Problèmes particuliers du déséquilibre de l'INR : De nombreux cas d'augmentation de l'activité des anticoagulants oraux ont été rapportés chez des patients recevant des antibiotiques. Le contexte infectieux ou inflammatoire marqué, l'âge et l'état général du patient apparaissent comme des facteurs de risque. Dans ces circonstances, il apparaît difficile de faire la part entre la pathologie infectieuse et son traitement dans la survenue du déséquilibre de l'INR. Cependant, certaines classes d'antibiotiques sont davantage impliquées : il s'agit notamment des fluoroquinolones, des macrolides, des cyclines, du cotrimoxazole et de certaines céphalosporines. GROSSESSE et ALLAITEMENT : Grossesse : Les études chez l'animal n'ont pas mis en évidence d'effet tératogène. En l'absence d'effet tératogène chez l'animal, un effet malformatif dans l'espèce humaine n'est pas attendu. En effet, à ce jour, les substances responsables de malformations dans l'espèce humaine se sont révélées tératogènes chez l'animal au cours d'études bien conduites sur deux espèces. En clinique, l'analyse d'un nombre élevé de grossesses exposées n'a apparemment révélé aucun effet malformatif ou foetotoxique particulier du métronidazole. En conséquence, le métronidazole peut être prescrit pendant la grossesse, si besoin. Allaitement : Le métronidazole passant dans le lait maternel, éviter l'administration de ce médicament pendant l'allaitement. CONDUITE et UTILISATION DE MACHINES : Il convient d'avertir les patients du risque potentiel de vertiges, de confusion, d'hallucinations ou de convulsions et de leur recommander de ne pas conduire de véhicules ni d'utiliser de machines en cas de survenue de ce type de troubles. EFFETS INDÉSIRABLES : Système gastro-intestinal : Troubles digestifs bénins (douleurs épigastriques, nausées, vomissements, diarrhée). Glossite avec sensation de sécheresse de la bouche, stomatite, goût métallique, anorexie. Exceptionnellement, cas de pancréatite réversible à l'arrêt du traitement. Peau et annexes : Bouffées congestives, prurit, éruption cutanée parfois fébrile. Urticaire, oedème de Quincke, exceptionnellement choc anaphylactique. Système nerveux central et périphérique : Céphalées, Neuropathies sensitives périphériques, Convulsions, vertiges, ataxie. Troubles psychiatriques : Confusion, hallucinations. Lignée sanguine : Très rares cas de neutropénie, d'agranulocytose, et de thrombopénie. Manifestations hépatiques : Très rares cas d'anomalies réversibles des tests hépatiques et d'hépatite cholestatique. Divers : Apparition d'une coloration brun-rougeâtre des urines due à la présence de pigments hydrosolubles provenant du métabolisme du produit. SURDOSAGE : Des cas d'administration d'une dose unique jusqu'à 12 g ont été rapportés lors de tentatives de suicide et de surdosage accidentel. Les symptômes se sont limités à des vomissements, une ataxie et une légère désorientation. Il n'y a pas d'antidote spécifique pour les surdosages de métronidazole. En cas de surdosage massif, le traitement est symptomatique. PHARMACODYNAMIE : Antibiotiques antibactériens antiparasitaires de la famille des nitro-5-imidazolés (J : anti-infectieux, autres antibactériens dérivés imidazolés. Espèces sensibles : Aérobies à Gram - : Helicobacter pylori (30 %). Anaérobies : Bacteroides fragilis, bifidobacterium (60 - 70 %), bilophila, clostridium, Clostridium difficile, Clostridium perfringens, eubacterium (20 - 30 %), fusobacterium, peptostreptococcus, prevotella, porphyromonas, veillonella. Espèces résistantes : Aérobies à Gram + : actinomyces. Anaérobies : mobiluncus, Propionibacterium acnes. Activité antiparasitaire : Entamoeba histolytica, Giardia intestinalis, Trichomonas vaginalis. PHARMACOCINÉTIQUE : Comprimés : Absorption : Après administration orale, le métronidazole est rapidement absorbé, 80 % au moins en une heure. La biodisponibilité par voie orale est de 100 %. Elle n'est pas significativement modifiée par l'ingestion simultanée de nourriture. Distribution Comprimé : Environ 1 heure après la prise unique de 500 mg, la concentration sérique maximale atteinte est, en moyenne, de 10 µg/ml. Après 3 heures, la concentration sérique moyenne est de 13,5 µg/ml. La demi-vie plasmatique est de 8 à 10 heures. La liaison aux protéines sanguines est faible : inférieure à 20 %. La diffusion est rapide et importante, avec des concentrations proches des taux sériques, dans les poumons, les reins, le foie, la peau, la bile, le LCR, la salive, le liquide séminal, les sécrétions vaginales. Le métronidazole traverse la barrière placentaire et passe dans le lait maternel. Solution injectable: L'injection de 500 mg de métronidazole par voie veineuse donne lieu, après perfusion unique, à un pic moyen de 18 µg/ml à la fin de la perfusion de 20 minutes. La demi-vie plasmatique est de 8 à 10 heures. La liaison aux protéines sanguines est faible : inférieure à 10 %. La diffusion est rapide et importante dans les poumons, les reins, le foie, la peau, la bile, le LCR, la salive, le liquide séminal, les sécrétions vaginales. Le métronidazole traverse la barrière placentaire et passe dans le lait maternel. Suspension buvable. Diffusion : La liaison aux protéines sanguines est inférieure à 10 %. La diffusion est rapide et importante dans les poumons, les reins, le foie, la peau, la bile, le LCR, la salive, le liquide séminal, les sécrétions vaginales. Le métronidazole traverse la barrière placentaire et passe dans le lait maternel. Excrétion surtout urinaire EXPLOITANT : Sanofi aventis - Immeuble EPI - Rue de Ziguinchor x Rue de Diourbel - point E 43 BP 3529 - Dakar Sénégal - Tél. : (221) 33 865 02 02 / fax: (221) 33 864 23 93 / Site web : http://sn.sanofi-aventis.com/

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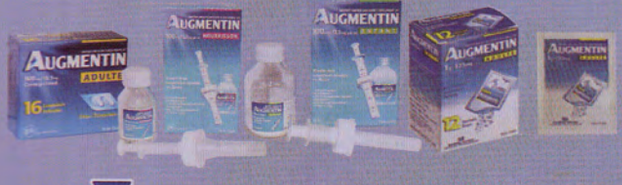

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In patients developing a fistula after their first delivery, 93 (71.0%) had a vaginal delivery, 35 (26.7%) had a c-section and 3 (2.3%) had a VAVD. 66 (64.0%) delivered at a hospital and 36 (35.9%) delivered at home. 89.8% of patients labored >2 days and delivery resulted in a stillbirth in 77.5%. In multiparous patients 47.7% had a vaginal delivery and 46.8% a cesarean delivery. Similarly for the last delivery, 76.2% labored for >2 days, 83.5% delivered at a hospital and 76.6% (n=85) resulted in stillbirth. 62.7% (n=118) identified themselves as married, 19.1% (n=36) as separated, 16.6% as widowed or single. 71.6% of patient had no prior fistula repair.

Of 215 patients, 180 had vesicovaginal fistula, 7 had uretero-vaginal fistula, 12 had utero-vaginal fistula and 16 had a rectovaginal fistula (6 were isolated rectovaginal). Fistulas were classified using a dual classification system for future outcomes analysis. 87 (42.6%) involved the urethra and 42 of these had circumferential damage. Mild scarring was identified in 87 (43.5%) patients, fistula size >3 cm in 27 (14.8%) patients and distance of the fistula from the urethral meatus from 1.5 - 2.5cm in 88 (47.3%) patients.

153 (73.6%) of the fistula repairs were primary, 35 (16.8%) were secondary and 20 (9.6%) were tertiary or greater repair. The majority of repairs were done in a single layer (97.0%, n=193). 26 (12.5%) fistula repairs were done abdominally; the remaining were completed vaginally.

Median follow-up time after repair was 14 days (range 7- 43 days). At longest follow-up 180 patients (88.6%) had successful closure of the fistula, 12 were lost to follow-up. 32 (15.8%) patients continued to have residual urinary incontinence.

Conclusion

Obstructed, unmonitored labor is the primary risk factor for obstetric fistula in women in Eastern Democratic Republic of Congo Most patients traveled from outside the region to seek care and evaluation of their first fistula. Almost half the fistulas involved the urethra, 50% with circumferential damage. The high percentage of fistula after c-section suggests the need for increased training in operative delivery. The overall closure rate was similar to previous studies as was the rate of residual incontinence.

Treatment of post-obstetrical urethral damage
Traitement des destructions urétrales post-obstétricales

Ludovic FALANDRY, Gabon/France

Objectifs

Description d'une technique originale de reconstruction urétrale par lambeau labial pédiculé retourné simple ou double face, pour le traitement des lésions urétrales étendues d'origine obstétricale.

Cette technique réalisée à l'aide d'un lambeau pédiculé prélevé au niveau de la grande lèvre et/ ou de la petite lèvre utilise deux types de plastie :

- • Plastie de comblement allongement par patch
  • Plastie tubulée de remplacement

L'urétroplastie labiale double face est une variante qui utilise les deus faces de la petite lèvre.

La continence urinaire est assurée dans la plupart des cas par une fronde graisseuse sous urétrale de Martius. Une colposuspension lui est associée en cas d'échec.

Sur 52 patientes analysées avec un suivi moyen de 23 mois la récupération d'une miction normale et l'absence de fuite a été obtenue dans 36/52 cas (69%). Il y a 7 améliorations (13%) et 9 échecs (17%).

Conclusion

Utilisée depuis 1992, la reconstruction urétrale en un temps, par lambeau labial pédiculé simple ou double face et fronde graisseuse sous urétrale apporte une solution élégante et satisfaisante pour le traitement des formes graves avec urètre détruit (que nous qualifions de type II par opposition aux lésions moins étendues de type I) jusque-là considérées de réparation très difficile et pour lesquelles une dérivation urinaire était proposée.

Prevention and management of obstetric and traumatic fistulae
Prévention et prise en charge des fistules obstétricales et traumatiques

Sita Millimona, EngenderHealth

TContexte

Depuis janvier 2007, Engender Health, dans le cadre du projet global Fistula care financé par l`USAID, met en œuvre un projet multisectoriel et intégré de prévention et de prise en charge de fistules obstétricales et traumatiques en Guinée. Les composantes du projet incluent la prévention, la réparation chirurgicale de la fistule, la réintégration des clientes souffrant de fistules et la gouvernance démocratique locale.

Objectif

Renforcer un environnement favorable á l`institutionnalisation de la prévention et de la réparation des fistules ainsi que de la réintégration des femmes souffrant de cette pathologie.
Hypothèse: S'attaquer de manière holistique aux racines profondes des fistules maximise les résultats de la lutte contre les fistules.

Méthodologie

Trois niveaux de traitement

Sites niveau I Traitement limité et référence
Sites niveau II Réparation de fistules simples et référence.
Sites niveau III Réparation de fistules simples et compliquées.

Formation de chirurgiens locaux

Prévention

Formation en cascade des prestataires des services en SONU. Stratégie de proximité utilisant des Comités Villageois.

Réintégration

Immersion sociale des clientes dans des familles d`accueil comme thérapie psychosociale.
Gouvernance Démocratique Locale: Transparence et participation citoyenne dans la mobilisation et gestion des ressources financières locales.

Résultats

- Les comités Villageois ont créé un véritable lien structurel entre les communautés et les structures sanitaires.
- L`immersion sociale contribue à la résolution de leur problème émotionnel et psychologique.

Gouvernance Démocratique Locale a permis aux communes de générer d'importantes ressources financières dont une partie est allouée aux activités de prévention et de prise en charge des fistules.

Conclusions

L`alliance stratégique avec les communautés est essentielle pour la pérennisation de tout programme de Santé. Bonne Gouvernance et transparence sont deux facteurs clés pour le renforcement de la participation citoyenne dans toute action publique.

Challenges in treating obstetric fistula in a developing nation
Défis dans le traitement des FO dans un pays en développement

Richard Manning, CURE International Hospital Kabul, Afghanistan

Background

Obstetric fistula epitomizes challenges of providing health care in developing nations. Providers are confronted with patients harboring complex or in-operable OFs who have traveled long distances only to discover there is little hope for surgical cure. This poignant scenario can prompt a novice surgeon and hospital staff into operating on OF beyond their expertise.

Objective

To review all OF work at CURE International Hospital Kabul, Afghanistan focusing on results as a function of time, complexity of disease and available expertise at the time of operation.

Methodology

We retrospectively reviewed charts of 92 consecutive OF patients operated on from January 2006 through June 2010. 19 had 35 prior attempted repairs. The ureter (5), urethra (4), rectum (1) were involved in 82 VVFs. Ten were recto-vaginal fistulas. 8 OFs were operated on by a senior surgeon before formal training of OR staff or ward nurses. The remaining 84 OF cases were done by two Afghan OB/GYN surgeons and two nurses who had received training at Addis Ababa Fistula Hospital in Ethiopia. A visiting senior surgeon attended 16 of this 84.

Results:

64 of 92 OF patients (70%) left CIH completely continent. Complete continence by year from 2006 through 2010 was achieved in (38%), (78%), (73%), (52%), and (88%) of cases respectively. 12/19 (63%) of redo cases failed. 8/24, (33%) of cases performed with and 20/68, (29%) of cases performed without a senior surgeon resulted in failure. 5 failures occurred in 2006 before operating room and nursing staff were formally trained. 2 urethral, 1 ureteral and 1 rectal repair failed.

Conclusions

Our results demonstrate common difficulties encountered when setting up OF treatment centers in developing nations. Lack of experienced surgeons, and OR staff, case complexity and redo surgery all negatively impacted results. Difficult cases must be delayed until necessary expertise is present.

The Value of Preoperative Abdominal Ultrasound in Patients with an Obstetric Fistula
La valeur de l'échographie abdominale préopératoire pour les patientes atteintes de fistule obstétricale

Gordon Williams, Medical Director Addis Ababa Fistula Hospital, Ethiopie

Background

This study is the first to investigate the value of abdominal ultrasound in large numbers of women with a VVF of obstetric origin

Objective

Ureteric displacement to the margin of the fistula or outside the bladder where it may not be identifiable during surgery is a well recognized consequence of obstetric fistulae. It was our impression that this was more common in women who had undergone previous lower abdominal surgery.

Methods

Three hundred and sixteen women with a VVF underwent pre operative abdominal ultrasound. A lower abdominal scar usually as a result of caesarian section was present in 156. The site of the ureteric orifices was recorded at fistula repair in all cases.

Results

One or both ureters were outside the bladder in 52 patients (16.4%) and it was twice as common in those who had undergone previous abdominal surgery. There was a significant relationship between ureteric displacement from the bladder and previous abdominal surgery ($p<0.05$). The position of one or both ureters on the fistula margin was identical in both groups and was present in 95 of the patients (30%). Ureteric dilatation was present on ultrasound in 41 of the 57 ureters outside the bladder (70%) and was more common in those who had undergone previous surgery. Ureteric dilatation on pre operative US was significantly associated with ureteric displacement ($p<0.05$).

Conclusions

The finding of ureteric dilatation on a pre operative ultrasound is associated with a ureter(s) outside the bladder particularly in those who have undergone previous lower abdominal surgery. These patients should only be operated on by surgeons experienced in dealing with this problem.

Adult Non-formal Education in Rehabilitation and Reintegration of Fistula victims
Education non-formelle des adultes dans la réhabilitation et la réintégration des victimes de fistule

Selashi Legessie Fentaw, on behalf of Adult and Non-formal Education Association in Ethiopia

Background

For over twenty years the Addis Ababa Fistula Hospital has been carrying out ileal conduit urine diversions for those with inoperable fistulae .For cultural reasons they cannot return home. In the past 6 years they have been housed in a rehabilitation center near the hospital and taught basic literacy and numeracy skills and exposed to agricultural based activities. The women were very dissatisfied, with negative attitudes towards the external world and did not want to leave the center which they considered their home for life.

Objective

To assess the value of an integrated adult learning program in building self confidence, critical thinking and actions to win life's challenges within their own context.

Methods

The part time course ran for 8 months involving 36 women and included focus-group discussion, reflection, triangulation, consensus building and field visits.

Results

The learners have become capable of basic literacy and numeracy skills and are approved by the education department to pursue formal education at grade four. They have gained self confidence of living and winning life through reintegration into the community and readiness to start their own life/business with the hospital providing minimal essential support.

Conclusions

This participatory integrated approach has resulted in a better learning achievement in less time. This may not be sufficient to ensure effective reintegration, so strengthening the current program and systematic follow up of these women's learning activities is essential.

"Superbugs" and Fistula Patients: What should we do?
« Superbugs » et les patientes porteuses de fistules : Qu'est-ce qu'on doit faire ?

Gordon Williams, The Addis Ababa Fistula Hospital PO Box 3609 Addis Ababa Ethiopia

Background

Background: Multi resistant strains of bacteria are becoming increasingly common and have resulted in the death of many patients. This is the first report of the very common occurrence of multi resistant bacteria in the urine of women with a vesico vaginal fistula.

Objective

To determine the frequency of multi resistant bacteria in the urine of patients presenting to the Addis Ababa Fistula Hospital and the effect on patient and operative outcomes

Methods

Two hundred consecutive newly presenting patients with a VVF had their urine cultured and the bacterial sensitivities determined at presentation and two days before the removal of their catheter. An open system of urine drainage was used throughout the study period. Post operative infectious episodes, treatment and outcomes were recorded.

Results

Only 29 had a sterile urine at presentation and eighteen, two days before catheter removal Antibiotic sensitivities were determined against Ciprofloxacin,

Norfloxacin, Nitrofurantoin, Chloramphenicol, Gentamyci n and Ceftriaxone, Fifty four had a fully sensitive bacteria, fourteen a bacteria sensitive to only one antibiotic and 12 sensitive to two. Three patients had a bacteria resistant to all antibiotics. Multi resistance was most common in E. Coli , Proteus and Klebsiella species. Gentamycin given at surgery to some patients did not appear to be of benefit. Sixty six bacteria were resistant to Gentamycin. Only 18 patients had a postoperative septic episode and made a full recovery.

Conclusions

Antibiotic resistance is common and likely to be due to the widespread availability of antibiotics in the markets. A closed system of urine drainage should be used and antibiotics only used according to bacterial sensitivities. Antibiotic prophylaxis has no role in fistula patients when the urine is already infected. Augmentin and Ceftriaxone are currently the only antibiotics with a high rate of effectiveness.

Reflections on the classification of "African" OF
Quelques réflexions sur la classification de la fistule obstétricale (FO) ''Africaine''

Kalilou OUATTARA, Centre de Référence et de Formation en chirurgie de la FVV Hôpital (CHU) du Point G –Bamako, République du Mali.

Comme vous le savez l'unanimité de n'est pas obtenue autour de la classification de la fistule obstétricale. Si dans le monde anglophone c'est la classification de Kees Waaldjik qui est la plus usitée, dans le monde francophone aucune classification ne s'est pas encore imposée L'objectif de notre communication est de vous faire part notre classification fruit d'une longue expérience de la prise en charge de cette catégorie de malades tout en faisant une comparaison avec celle proposée par Kees Waaldjik.
Cela dit nous pensons que deux critères sont a prendre en compte : l'environnement de la Fistule, la localisation anatomique.

Selon le premier critère nous distinguons les

- **a)** Fistules sur vagin souple
- **b)** Fistules sur sclérose vaginale (brides, sténose ou atrésie vaginale)
- **c)** FVV associée à une Fistule recto- vaginale (haute ou basse) ou à une déchirure du périnée (I, II, III ème degré).

Selon le second critère :

- **a)** Fistules types de la cloison Vésico-Vaginale (Type I de Waaldjik)
- **b)** Fistules Vésico- cervico-uretrales (Type II de Waaldjik) dont les variétés sont :

  Sans destruction de l'urètre :

  1. Fistule cervico-uretro-vaginale : Type II Aa selon Waaldjik
  2. Désinsertion (trans-section) cervico-uretrale partielle .Type IIAb selon Waaldjik
  3. Désinsertion (trans-section) cervico-uretrale totale Type II Ac (Non individualisé par Waaldjik)

Avec destruction de l'urètre (Type II B selon Waaldjik)

- **c)** Fistules Trigono - Cervico-Utéro-vaginales (Non individualisées par Waaldjik)
- **d)** Fistules mixtes complexes
- **e)** Fistules hautes Dont les variétés sont :
  1. Vésico-cervico-utérine
  2. Vésico-utérine classique

Conclusion

Nous dirons que notre classification est simple et non simpliste avec une certaine analogie avec celle de Waaldjik. Cependant nous pensons qu'on ne peut prévoir réellement l'atteinte de l'appareil sphinctérien qu' après avoir opéré les fistules situées sur le segment cervico-uretral et l'atteinte de l'appareil sphinctérien ne peut être pris d'emblée pour définir un type de fistule. Par ailleurs il y a lieu d'individualiser les fistules qui touchent le col utérin et le trigone vésical car ces cas posent des problèmes techniques (prise ou blessure des uretères lors de leur cure chirurgicale. Elles doivent être opérées par voie basse si au préalable les méats urétéraux ont été identifiés et catheterisés et par voie haute si tel n'est pas le cas.

Mots Clés

FVV, Classification

Immediate management of obstetric fistula
Prise en charge immédiate de la FO

Dr Imam Amir Yola, Laure Fistula Center Kano, Nigeria

Abstract

As the incidence of obstetric fistula is still high certain measures have to be considered so as to reduce the number of those unfortunate VVF patients from being ostracized and stigmatized. Use of an indwelling catheter and early closure are adopted as means to curtail the above mentioned menace and to reduce the number of those awaiting surgery.

Keywords

early closure, catheter, ostracized, stigmatized, obstetric fistula.

Introduction

Immediate management of obstetric fistula refers to the action taken within the first three month postpartum in any woman who presents with urine leakage, be it by vagina or by caesarian section the cardinal causes of urine leakage in association with obstetric fistula are VVF itself atomic bladder UV stricture and stress incontinence. They all present with continuous dribbling of urine per vagina but with different underlying pathophysiology, as such is managed uniquely even so the use of an indwelling Foley catheter is the basic concept

It involves the use of an 18F Foley catheter because of its size that allows drainage of large amount of urine and lesser chances of blocking with open or close drainage as it applies. The other method is by early closure of the fistula after refreshing the edges and putting an indwelling catheter for 4-6 weeks to ensure continuous drainage of the bladder.

Methodology

In a patient who presents with urine incontinence or leaking of urine an 18F Foley catheter is inserted through the external urethral orifice (EUO) into the bladder after measuring the depth of the bladder and deducing the length of the urethra using the distance between the balloon of the catheter and the EUO. This balloon is inflated with 5-10ml of savlon and left in for weeks to allow for the bladder compression in cases of intrinsic stress incontinence, urethral stricture or early closure.

In the entire aforementioned conditions catheter is the mainstay treatment so as to ensure continuous bladder drainage and decompression.

Vesicovaginal fistula of not more than 2cm in diameter is treated with catheter alone or in combination with surgery. In this case the fistula edge is freshened by dissection of the bladder from the anterior vaginal wall and closing each separately.

In the case of atonic bladder with overflow incontinence where 'the detrusor muscle fibers have been overstretched to such an extent that they cannot contract anymore' (Kees 1996) the bladder depth is measured using a uterine sound and in almost all the cases (92%) it measures between 16-18cm and it measured more than 20cm in 8% of the cases. The urine volume can reach up to a gallon in more than 80% of the cases and the bladder mass palpable at suprapubic can rise up to 20wks size uterus. In this situation Foley catheter 18F is inserted via the EUO and left in for 4-6 wks to allow for decompression and for the bladder detrusor muscle to regain its tensile strength.

Compression trauma at the urethrovessical (UV) junction leaves a trace as a stricture development which distorts the macro anatomy/physiology of urine incontinence thereby resulting in overflow incontinence. The stricture has to be released first using different sizes of dilators and then an indwelling catheter inserted for 4wks and if a fistula is located it should be closed there and then.

Stress incontinence with overflow is as a result of cutting off (partial or complete) of the Pubocervical fascia which happens to play a key role in physiologic control of urine voiding. This is marked by partial or complete loss of vagina rugae with or without a fistula. Use of catheter or in combination with surgical repair provides an ultimate solution.

Results

Two hundred and thirty six (236) patients treated by means of immediate management of obstetric fistula (OF) and the following was deduced

Table 1 : cases vs treatment

Case type	Catheter alone	With early closure	
VVF	14 (15.28%)	78 (84.78%)	92
Atonic bladder	28		28
UV stricture	7 (35%)	13 (65%)	20
Stress incontinence	35	61	96
			236

The table above displays the type of the case and the treatment modality i.e. whether catheter alone or in combination with early closure. In cases where the fistula is less than 2cm use of catheter alone suffices but where the fistula is more than 2cm in diameter then refreshing the edge of the fistula and closing it with sutures is mandatory in facilitating quick healing. In the case of atonic bladder where the bladder depth was measuring more than 16cm, after 4-6 weeks on catheter all the patients (28) were fully continent and dry. In the case of UV stricture after graded dilation of the urethra and release of bands a catheter is left in for 6weeks after which 65% were successful with catheter alone and the other 35% in combination with surgery.

Table 2 : success rate

Case	Catheter	Early closure
VVF	14(100%)	78 (86%)
Atonic bladder	28(100%)	
UV stricture	7(63%)	13(79%)
Stress	35((84%)	61(92%)

The table above displays the type of case and the treatment modality i.e. whether catheter treatment or in combination with surgery.

Use of catheter in cases where there is no fistula have a better prognosis of complete healing and gives a high chance of complete continence, likewise in the case of early closure the success rate is also good being 86% of the cases are healed.

Treatment of atonic bladder with catheter alone gives a very high hope as almost all are healed; only one patient needed another mode of treatment.

After graded urethral dilatation 10 patients out of 13 treated with catheter alone were dry after 4 weeks and 5 patients out 7 treated with combined early closure and catheter were dry after 4weeks.

61 patients with stress incontinence out of 96 were completely treated (dry) and or the other 35 patients some other methods had to be adopted.

Immediate treatment of obstetric fistula with catheter will obviously reduce the number of those awaiting surgery as passive attention to the fistula will heavily help in primary healing because the bladder detrusor muscles will rest and the wound edges will come together provided there is no necrotic tissue around.

Strategic Choice of WAHA international in obstetric fistula treatment, prevention and training

Choix stratégique de WAHA International en matière de traitement, prévention et formation au traitement de la fistule obstétricale

Mulu Muleta (WAHA) & Fatouma Mabeye (WAHA), Ethiopia

Most fistula care and training services operate outside the government health sector often involving surgeons who come for short visits. The very few non-governmental specialized fistula repair and training centers are unable to meet the enormous need for fistula care and training services.

There is however general consensus for the need of improved access to treatment, manpower providing different level and type of fistula care, need for financial resources, and hence need for better approach (strategy) for the services.

Women and Health Alliance International following alternative strategy (in line with national plan) to maximize access to quality care is working with government teaching institutions in Ethiopia and 17 other developing countries. This is through integrating fistula care, prevention and training service to public teaching institution; capitalizing on local capacity building and community involvement. WAHA International synchronizes these fundamentals of global strategies in obstetric fistula care, prevention and training services, with the precedence of public institutions.

Integrating the care of women with other services is proven to be efficient, cost effective and sustainable; local capacity building strengthens the health system of the country and community mobilization scale up the intended interventions.

Consequently, integrated service for women's health and focus on local capacity building is indispensable strategy for sustainable development.

Niger fistula prevention experience

Experience de la prevention de fistule au Niger

Anders Seim, Norway

Immediate obstetrical fistula management and preventing the woman from becoming an outcast by early closure and catheter treatment at general hospital level

Prise en charge immédiate de la fistule obstetricale et la prévention de la stigmatisation de la femme par fermeture précoce et traitement par cathétérisme au niveau de l'hôpital général

Mulu Muleta (WAHA) & Fatouma Mabeye (WAHA), Ethiopia

Introduction

Obstetric fistula management is still a very controversial issue because of the little number of surgeons engaged in it. This neglect is occasioned by the main cause of obstetric fistula which is poor obstetric care and the inability of most of the patients to pay for care. Recent focus on the problem now calls for provision of effective methods of obstetric fistula management. It has been reported that 20-25% of all OF can be healed by inserting a catheter the moment urine leakage becomes manifest. (Waaldijk K) The objective of this study is to assess the effectiveness of immediate management of fresh obstetric fistula (less or equal to 75 days duration) by catheter treatment and / or early closure.

Materials and Methods

257 OF patients who presented with fresh obstetric fistula and / or overflow incontinence over a period of 4 years (2006 – 2009) were managed at one of the 4 Fistula repair centers i.e. (MMSH, BBRFH, WDLGH & JHGH) in the North West region of Nigeria and the results analyzed. All patients with fistula that is less than 1 cm in diameter or with overflow incontinence had a Foleys catheter size 18 inserted for a period of 3 – 6 weeks. All other patients were clinically assessed and subsequently operated upon by the authors. Pre Operative preparation included high oral fluid intake, an enema the day before surgery and fasting from midnight. Post operative care with high oral fluid intake and early ambulation were affected. Antibiotics were prescribed only on indication. Prophylactic antibiotics were administered only when there is fecal contamination of the operating field. Patients were managed till discharge and were followed up for 6 months.

Results

Total numbers of patients dry after
Catheter Treatment 40
Total numbers of patients dry after
1st attempt at repair 196
Total numbers of patients dry after
1st attempt at repair plus bladder drill 4
Total numbers of patients dry after
2nd attempt at repair (urethralisation) 15
Broken down 1
Absconded 1

The result above approximates to;
92% dry at 1st attempt
99% dry at 2nd attempt
<1% broken down

Recommendation

Catheter / early closure can be recommended for management of obstetric fistula in African settings with good outcome.

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OF ..... Obstetric Fistula
MMSH ..... Murtala Mohammed Specialist Hospital – Kano Nigeria
BBRFH..... Babbar Ruga Fistula Hospital – Katsina Nigeria
WDLGH ..... Wudil General Hospital – Kano Nigeria
JHGH ..... Jahun General Hospital – Jigawa Nigeria

The immediate management of fresh obstetric fistulas
La prise en charge immédiate de la FO fraîche

Kees Waaldijk, MD PhD, Babbar Ruga Fistula Teaching Hospital, Katsina, Nigeria

Objectives

It has been a general rule to wait with the repair of an obstetric fistula for a minimum period of 3 months allowing the patient to become an outcast. In a prospective way an immediate management was studied and antibiotics were not used, all according to basic surgical principles.

Method

A total of 1,716 patients with a fistula duration of 3-75 days after delivery were treated immediately upon presentation by catheter and/or early closure. Instead of antibiotics a high oral fluid regimen was instituted. The fistulas were classified according to anatomic and physiologic location in types I, IIAa, IIAb, IIBa and IIBb, and according to size in small, medium, large and extensive. The operation became progressively more complicated from type I through type IIBb and from small through extensive.

Results

At first attempt 1,633 fistulas (95.2%) were closed and another 57 could be closed at further attempt(s) accounting for a final closure in 1,690 patients (98.5%); 264 patients (15.4%) were healed by catheter only. Out of these 1,690 patients with a closed fistula 1,575 (93.2%) were continent and 115 (6.8%) were incontinent. The results as to closure and to continence became progressively worse from type I through type IIBb and from small through extensive. Postoperative wound infection was not noted; postoperative mortality was encountered in 6 patients (0.4%).

Conclusion

This immediate management proves highly effective in terms of closure and continence and will prevent the patient from becoming an outcast with progressive downgrading medically, socially and mentally

Keywords: obstetric fistula; immediate management; catheter; early closure

Perceived causes and burden of obstetric fistulae and coping mechanisms of women attending fistula clinic in Mulago Hospital, Uganda.

Joan Kabayambi, Uganda

Introduction

Obstetric fistula (OF) results from failure to relieve obstructed labour. The increased pressure of the fetal head during prolonged obstructed labor eventually leads to tissue death and eventually fistula. Though through Surgery, fistulas can be closed, there were no studies that had been done to describe the burden of fistula to the victims and how they cope with this challenging morbidity among women in Uganda. It was also not clear what the women perceived as the cause of the fistula. This study was hence conducted to assess the burden of fistula to patients, the coping strategies and the perceived causes of fistula among women attending Mulago fistula clinic in the Uganda's capital Kampala.

Methods

This was a cross sectional descriptive study among women attending the fistula clinic. A structured interviewer administered questionnaire was used to collect the data. All patients who satisfied the inclusion criteria of having an OF and had consented were interviewed. The data was then enriched by conducting FGDs, KI interviews and review of patient's documents. The data was then coded, summarized, entered in the computer using EPI INFO version 6 and analyzed using SPSS version 4. Analysis was done using thematic summaries, tables and graphs.

Results

A total of 50 respondents were interviewed. Respondents were ranging from 13-69 years; the mean age at presentation to the clinic was 27years. The mean and median age at the time they sustained fistula was 21 and 18 years respectively, a total of 72% developed OF at < 25 years. A total of 62% sustained fistula during their first pregnancy and 34% during their 2nd to 6th pregnancy. Causes of OF: A total of 23.3%

attributed the cause to accidental injury of the bladder during birth by medical officers using clinical instruments, (20%) attributed it to delivering of a big baby, (51.7%) cited hospital procedures, 10% to witchcraft, 13% to delayed labor, 15.5% to village birth attendants and 17.9% to a self retaining catheter.

The burden of fistula identified included

Long years living with OF (30%), loss of marriages (20%, isolation (23.3%), loss of freedom to associate (13.3%), lack of self confidence (13.4%), inability to work (13.3%), and stigma (63%). Families were affected due to high costs of treatment (43 %), provision for basic items (32 %) and suffered from stress (55%) and all had lost their children. Coping Strategies: The following were some of the ways the patient employed to cope with this devastating condition: Keeping clean and washing all the time (83%), drinking a lot of water to reduce the smell and sores due to the urine (80%), ignoring people's comments (75%), seeking refuge from the pastor in churches (30%), prayer (57%), eating/drinking less (13%) and keeping busy with making handcrafts (8.9%).

Conclusions

Regardless of age and parity women are likely to develop fistula these findings are unlike what is cited in the available literature that OF predominantly affects very young girls on their first pregnancy. Obstetric fistula is more than just a hole in the bladder as seen from the burden it adds to patients. There is also misconception as to what causes obstetrics fistula as seen from the perceived causes and coping strategies from patients

Recommendations/practical implication

OF is a public health issue requires attention from both clinical and public health perspectives. Medical workers need to understand the way patients perceive the causes of fistula and be able to inform policy makers and also help counseling the affected women. Girl child education may help to dispel the misconceptions and also empower women to recognize risks to developing fistula and hence prevent fistula. The results also may help during counseling of victims and educational programmes targeting spouses, families and the community to reduce the stigma.

VVF surgical camp outreaches the way to manage the VVF patient backlog: experience of Mulago VVF unit

Causes aperçues, le fardeau de la FO et les stratégies d'adaptation des femmes à la clinique de traitement de la fistule à l'hopital de Mulago, Uganda

Barageine Justus Kafunjo, Mulago national referral Hospital, Kampala Uganda

Introduction

Globally there is an estimated backlog of fistula patients of about 2 million women. Despite global efforts, MDG 4 and 5 are still far from being achieved especially in Sub-Saharan Africa. In Uganda the MMR is 435/ 100,000 live births and for every mortality about 3 times the number of women will be left with severe morbidity of which fistula is one of the commonest in low income countries. In Uganda the ANC attendance (1st visit) is above 90% but deliveries in attendance of skilled birth attendant is only at 42 % and the rest deliver in villages under unskilled attendance if any. The Uganda demographic and health survey 2006 estimated a prevalence of 2.6 % among women. Mulago is the main centre in the country where routine fistula surgery is done in the Urogynaecology division but only 14 beds are available for this service where patients stay for average 18 days. Occasionally surgery is interrupted by other pressing issues in a government hospital like supplies, no anaesthetist and university calendar hence if every 3 weeks 14 patients are operated this leaves most of the patients on waiting list. The VVF patients are poor and hence cannot afford the transport costs along to the referral hospital. It was against this background that an outreach program was started to cover the catchment areas for this referral hospital.

Objectives of the program

To Screen and Repair VVF Patients, start CMEs for staffs in the unit on updates in fistula care. Provide support supervision to service providers in matters of safe motherhood especially prevention/management of obstetric fistula and obstructed labour. Interact with patients in matters of emergency obstetric care/safe motherhood especially ANC. Assess the community/heath service provider practices in issues of obstetric fistula prevention and care in form of operations research.

Methods/process

The heads of the units to be visited were contacted and patients mobilized FM radio announcements in the local languages. UNFPA, AMREF and MOH- Mulago hospital provided logistics in terms of transport for the surgeons, DSA, heath facility reimbursement for the expenses incurred, supplies and mobile kits. A team of 2 surgeons, one theatre nurse anaesthetist and driver would join the campsite staffs whatever the cadre. Patients were screened on the first day and surgeries would continue for 5 days. CMes would be provided especially on updates of fistula management and printed instructions left after five days for reference. Consultations would continue on the mobile telephones.

Results/ outreach Output

These included Number of outreaches conducted, patients screened and repaired, number of staffs attending the CMEs and the village/community meetings carried out. The detailed results will be presented. It was clear that in one week average of 40 fistula patients would be repaired compared to 7 patients that were routinely repaired in one week. The unit staffs were oriented in fistula management and now we have started training local teams to manage simple fistula and also be able to classify and refer difficult patients to Mulago. Patients have no limitations in transport costs. Details of the intervention will be presented including problems meet.
Recommendations: This model can be used to reach all areas in the country and even help to interest the future to be fistula managers. This also helps where human resource is limited since the one week outreach is labour intensive.

Knowledge, attitude and perception about obstetric fistula by Cameroonian women: A clinical survey conducted in Maroua, the capital of far north province of Cameroon.

Connaissances, attitudes et perceptions concernant la fistule obstétrique parmi des femmes camerounaise: une étude clinique menée à Maroua, la capitale du province de l'extrème nord du Cameroun

Pierre Marie Tebeu & Luc de Bernis, University Hospital, Yaounde Cameroon

Introduction

This study seeks to identify what the women who live in Maroua Cameroon know and think about obstetric fistula.

Population and method:

It is a single hospital, cross-sectional, descriptive and comparative study. Ninety-nine women in the maternity service of the Maroua Provincial Hospital were interrogated on obstetric fistula between May and July 2005, by enquirers who were trained health agents using a questionnaire which required both closed and open answers.

Results

The women who had no previous knowledge of it were generally the illiterate (41.7% compared to 18.8%). More than a third of the women who had an idea of the fistula do not know that there is a surgical treatment for it. Whether they had the previous information on fistula or received it from us, one-tenth of the women suggested that suicide was the solution to fistula where as one-third of the women suggested that a patient suffering from fistula should be isolated.

Conclusion and interpretation

Illiteracy contributes significantly to the lack of knowledge of this affection. The population has a poor perception and a strong negative attitude towards obstetric fistula as they see isolation or suicide as the solution to it.

Key words: Knowledge

Perception attitude; Obstetric fistula; Maroua; Cameroon

Efficacy of a multidisciplinary strategy for obstetric fistula management: Tanguieta Model in Benin

Efficacité d'une stratégie intégrée pour la prise in charge de la fistule obstétricale: Le modèle de Tanguleta au Bénin

Benski Anne Caroline, Stancanelli G, Rochat CH; Switzerland

Background

Obstetric fistula is a devastating medical condition. It is preventable with education and family planning, and curable with skilled medical assistance and low technology surgery. Our research was performed in the northern part of Benin, West Africa, a region with a very high maternal mortality rate and consequently high prevalence of obstetric fistula.

Objective

To evaluate the long term efficacy of the Tanguieta Model of obstetric fistula care as for clinical condition and socio-economics and to provide counselling for model implementation.

Methodology`

Our research was conducted among fistula patients who had surgery at the Saint Jean de Dieu Hospital. Patients came from rural areas of Burkina Faso and Benin and were interviewed at the hospital by medical staff and in their villages by two NGO's. Study analysis started in October 2008. Data about 136 consecutive patients were based on four interviews: the enrolment visit including socio-demographics, obstetric history, fistula history, physical examination and three follow up visits assessing physical outcome and social reinsertion after surgery over twelve months.

Results

Eight out of ten patients (76%) had their fistula repaired one year after surgery. The percentage of women with menses almost doubled from surgery to last interview (44% to 80%). Sexual activity and couple life were back to normal levels at the end of the study (90% and 86% respectively).

Conclusion

Existing studies have focused so far on the short term outcome of fistula surgery. But fistula closure after surgery does not necessarily mean the patient is permanently cured.
Our initial results are encouraging because they indicate that the implementation of the Tanguieta model therapy provides fistula closure and enables social reinsertion of fistula patients in the long term. Our findings should be confirmed on a larger scale in order to validate these results.

Bacterial Multi-drug Resistance and the Obstetric Fistula Patient

Multi-résistance bactérienne aux médicaments et la patiente atteinte de FO

Steven Arrowsmith, USA

Abstract

Although multi-drug resistant (MDR) infections are well documented in the developing world are well documented, this study addressed the issue in women in West Africa with obstetric fistula. This observational study looked retrospectively at the resistance patterns of bacteria encountered on a urine culture obtained prior to surgical repair. A total of 66 who patients presented to the hospital ship Africa Mercy in Liberia and Benin between September 2008 and February 2009 had urine cultures either at screening or admission. Although many definitions of MDR exist, if we use the criterion of resistance to at least 3 antibiotics, 44% had MDR. Twenty percent had bacteria resistant to 5 or more antibiotics. Our conclusion is that the incidence of MDR in the obstetric fistula population in these countries was surprisingly high. This significant finding has profound implications for the strategies of antibiotic prophylaxis and in the care of women with fistula who develop fever or become septic postoperatively. This is also a challenge in logistics, as the broad spectrum antibiotics effective in patients with MDR are expensive and most fistula centers operate with limited resources.

Incontinence after VVF
Incontinence après Fistule Vésico-Vaginale

Jérôme Blanchot, France

Residual urinary incontinence after obstetric fistula repair surgery
L'incontinence résiduelle des urines après fermeture de fistule obstétricale

Ludovic FALANDRY,

Objectifs

Proposer une technique simple, transvaginale, de correction de l'incontinence résiduelle des urines après chirurgie pour fistule vésico-vaginale post-partum. Le principe de la technique repose sur la création d'un « hamac » vaginal antérieur destiné à réaliser un soutènement de l'urètre et la suspension sus-pubienne de celui-ci par voie percutanée.
Sur 46 patientes suivies avec un recul moyen de 28 mois, (29) 63% sont guéries, (8) 17% sont améliorées et (9) 19,5% demeurent incontinentes. Le taux de succès global, (guérison et amélioration) est de 80%. Ces résultats qui sont à analyser en fonction du recrutement des patientes traitées sont moins bons chez les poly-opérées, après chirurgie pour lésion cervico-urétrale et pour les fistules du groupe III. Dans ce groupe moins d'une patiente sur deux est guérie ou améliorée.

Conclusion

Procédé simple et aisément reproductible le soutènement sous urétral par voie transvaginale, offre une alternative intéressante parmi les multiples solutions proposées pour le traitement des fuites urinaires après chirurgie pour fistule vésico-vaginale. Son efficacité à long terme nous a fait adopter son principe dans les incontinences résiduelles des urines après fermeture de fistule-obstétricale.

Postoperative Urine and Fecal Incontinence after surgical VVF/RVF repair, "Squeeze or relax, that's the question"
L'incontinence urinaire et fécale postopératoire après la fermeture de FVV/FRV

C.W.M. Haspels-Kenter PT, Waterland Hospital, Purmerend, Netherlands

A physiotherapeutic approach to help to reduce the number of women who, after having a VVF/RVF repair, still suffer from incontinence, dyspareunia or detrusor activity.

Introduction

In many African and Asian countries women are suffering from obstetric fistula. Obstetric fistulas are caused by prolonged obstructed labor without medical attention. Not only physical suffering, but also becoming a social outcast takes the women into an unbearable situation.

Prevalence

According to Gutman et al 1) 16% of the patients may develop urinary incontinence, after the first repair; Murray 2) reported that 55% of the patients are complaining of stress incontinence and 38% of fecal incontinence. (Browning et al 3) and (Goh et al 4) described that closing the fistula is not always sufficient, it may be anatomically satisfactory but functionally inadequate. Still suffering from urinary – and or fecal incontinence, grade 2 or 3, dyspareunia or detrusor activity is not life-threatening, but has a very serious impact on physical, psychological and social well-being Nielsen et al 5).

Findings

It is known since Kegel 7) 1948 en 1952 first described a correct pelvic floor contraction as squeeze around the urethral, vaginal and anal openings, and an inward lift that could be observed at the perineum.Vaginal or rectal palpation used to assess the ability of the patient

to contract and relax the pelvic floor muscles correctly, and to evaluate the pelvic floor muscle function.Laycock 1994 6) has developd a modified Oxford grading system, a six point scale to assess pelvic floor strength. From experiences of local surgeons(Kumi, Uganda,Kenia,T.Raassen, Nigeria K.Waaldijk) is known that these patients need a physiotherapist, also trained to do recto-vaginal or vaginal examination.(CCBRT Hospital, Dar Es Salaam, Tanzania 2004/2005)

Summary

It would be ideal if every physiotherapist, treating patients with pelvic floor dysfunctions, could have and give a proper training in the peri-operative treatment of the fistula patient contributing to a better life for the fistula patients. Multidisciplinairy teams could help to improve the quality of care of fistula patients in Africa and Asia 11).

Prise en charge des FVV à Nouakchott à propos de 50 cas
Management of VVF in Nouakchott: 50 cases

Yahya Ould Teil, Service d'Urologie CHN de Nouakchott

La fistule obstétricale reste en problème de sante publique en Mauritanie. Sont traitement ce améliore ce dernière années avec l'effort de l'état, l'Association Mauritanienne d'Urologue et l'UNFPA.

Matériel et méthodes

Nous avons réalise une étude rétrospective sur 11 ans porte sur 50 cas FVV colligées au CHN, Maternité de Sebkha et structures privées de juin 1999 à juin 2010

Résultats

La majorité de nos patientes ont un âge entre 15 et 30 ans. Une prédominance de FO chez les primipares parmi les patientes, sur ce plan notre' proportion est de 72.7%. Le manque d'aide obstétricale qualifiée est le facteur principal de survenue de la FO qui est l'apanage du milieu rural.

Conclusion

La FVV reste un problème majeur de santé publique en Mauritanie. les efforts déployés aux différents niveaux institutionnel; socioéconomique et obstétrical doivent continuer pour espérer l'éradication de cette pathologie qui constitue un véritable handicap pour la femme du fait de ses répercussions socioéconomiques, fonctionnelles et psychologiques.

A Retrospective Analysis of 315 Cases of Rectovaginal Fistulae
Une analyse retrospective de 315 cas de fistule recto-vaginale

Habtemariam Tekle, Addis Ababa Fistula Hospital, PO BOX 3609, Addis Ababa, Ethiopia

Background

Rectovaginal fistulae (RVF) are common in the developing world usually following obstructed labour. No large case series has examined the incidence, aetiology, management and outcome.

Objective

To identify the aetiologies, types, management and outcomes of RVF and determine factors which indicate outcomes.

Methods

In five years 315 patients presented with a RVF. Records were examined regarding aetiology, fistula type, concurrent vesicovaginal fistulae (VVF), repair technique, colostomy and outcomes.

Results

Patients with an RVF (n=315) accounted for 8.6% of all fistula presentations. 89.5% were caused by obstructed labour; 66.7% vaginal deliveries, 10.8% instrumental, 3.8% destructive, and 8.3% Caesarean

section. 70.9% sustained the injury when primiparous. Other aetiologies included post-coital, rape and accidents. Following obstructed labour 38.3% of fistulae were high, 31.2% mid-vaginal, 20.6% low and 9.9% combined. Of post-coital fistulae 20/22 were low. 85.1% obstetric cases had a concurrent VVF. A colostomy was performed in 67 patients. The majority of these fistulae were large and high and included 24 of 36 circumferential fistulae. 51 colostomies were performed at the fistula hospital and 16 elsewhere of which two required revision. 10 patients had post-operative colostomy-associated wound infections; two required re-closure. Seven colostomies were never closed; 2 RVFs were incurable; 4 patients did not return for follow-up and one patient died. Two-layer closure had a 93.9% success rate compared with one-layer closure (64.3%) or end-end anastamosis (76.2%). 87.6% (n=276) RVF were cured following the first operation and 18 after subsequent attempts. 70.4% of obstetric VVFs were closed at the first attempt.

Conclusions

The majority of RVFs were caused by obstructed labour and most patients had a concurrent VVF. Large, high and circumferential fistulae had worse outcomes. Low fistulae had the best prognosis. The value of a colostomy was not determined. To improve practice two-layer closure is preferable and better follow-up is required where repairs have failed.

Third and Fourth degree perineal tears,their presentation, aetiology and management

Déchirures périnéales du troisième et quatrième degré, leur présentation, étiologie et prise en charge

Habtemariam Tekle MD The Addis Ababa Fistula Hospital, Addis Ababa Ethiopia

Background

Women with perineal tears are frequently referred to fistula centres but little has been written on their aetiology and management.
Objective: To identify patient characteristics, aetiology, modes of delivery and treatment outcomes in women presenting with a third or fourth degree tear.

Methods

The case notes of the forty five women with a perineal tear who have been managed by the author in the last 4 years have been reviewed. All patients received pre operative bowel preparation and prophylactic antibiotics. The rectum was closed in two layers. An end to end anastamosis of the anal sphincter was carried out along with approximation of the perineal body. All patients were reviewed on discharge but no long term follow up is available.

Results

Twenty nine had a fourth degree tear and 18 a third degree tear. Thirty seven cases were due to childbirth and others due to rape, ox injury, fall injury or first intercourse. The age range was 8-58 yrs, mean 28yrs. Six were nulligravid and 17 para 1. Of the 37 who delivered 28 had a live birth. In the majority labor was < one day. Nineteen gave birth at home and 18 in an institution. Twenty mothers had a spontaneous delivery, 12 an assisted vaginal delivery and 1 a caesarean section. At discharge 43 were continent and some required laxatives. Two who had a residual pin hole fistula were closed at a later operation.

Conclusion

Perineal tears mainly result from the delivery of the first baby. A surprising number occurred in women who gave birth in an institution and should have been preventable with proper care. An end to end anastamosis of the anal sphincter provides excellent continence in the immediate post operative period though long term follow up would have been preferable.

What is required to improve access to health services in rural Ethiopia? A community based study.

Qu'est-ce qu'il faut pour renforcer l'accès aux services de santé en milieu rural en Ethiopie? Une étude communautaire

Mulu Teka, Ethiopie

Background

Lack of reproductive health knowledge (RH), distance and low women's status are known contributing factors for the high maternal mortality and morbidity in Ethiopia. There is a need for an explanation about the low level of health seeking during delivery even when services are free.

Objective

The aim of the study is to assess the contribution of knowledge and cultural practices related to RH and the role of transport and community support in the use of health services by women in order to design appropriate interventions to decrease maternal mortality and morbidity.

Methods

A cross-sectional quantitative and qualitative study was conducted in four regions. The participants were selected from 118 villages. Women who delivered a baby in the 30 months preceding the survey (n=2260), husbands/family members (n=2100), health practitioners of 72 health facilities, and 120 transport service providers participated. The qualitative research involved community and religious leaders.

Results

Most of the study participants had poor knowledge about RH. The mean age of marriage was 14±3.6 years. 43% of women gave birth for their first baby between 15-17 years. 60% of women sought ANC for their most recent pregnancy while 93% of women gave birth at home. About 12% faced problems related to delivery but less than half sought health care. Distance was the main reason for poor care seeking. The average time taken from decision to getting health services was 10.5 hrs. Transportation costs increase with the level of complication of the woman in labour. Transporting mothers during complicated labour was using locally made stretchers. Primary health care units were not ready to handle complicated labour.

Conclusion

Women in rural Ethiopia are vulnerable to negative reproductive outcomes due to lack of knowledge, access, lack of institutional readiness and transport facilities. Intervention on IEC, quality health care and transport is justified to decrease maternal mortality and morbidity.

Facility-level predictors of urinary fistula repair outcomes : Results of a multi-center prospective study.

Indices des resultats de la fermeture des fistules urinaires au niveau des structures

Mark Barone, EngenderHealth, USA

Background

Obstetric and traumatic fistulas are a significant cause of maternal morbidity in sub-Saharan Africa and Asia. While work to address fistula has been taking place throughout sub-Saharan Africa and parts of Asia, there are limited published data around facility-level factors, including pre-, intra- and post-operative procedures, that are associated with the outcome of fistula repair surgery. The primary study objective was to assess the association of these facility-level fistula repair practices with clinical outcomes.

Methods

Women were recruited for this multicenter, prospective, observational study at 11 sites in Bangladesh, Guinea, Niger, Nigeria and Uganda. Fistula services were provided according to the current practices at each study site. Staff at the study sites gathered data on standardized study report forms at admission to the study, during the clinical exam and repair surgery, during the hospital stay, and at a 3-month post-surgery follow-up visit. Because pre-, intra- and post-operative procedures varied between the sites we were able to examine the association of these different procedures with success of repair surgery. Bivariate associations were examined with chi-square or fisher's exact tests for categorical variables and t-tests for continuous variables. Multivariate general estimating equations (GEE) regression modeling was used to derive odds ratios and corresponding 95% confidence intervals for the association between facility-level factors and repair outcomes.

Results

Data were gathered from 1,285 women and girls,14-83 years old, between November 2007 to September 2010. Mean age at first marriage was 16.1 years, while mean duration of fistula was 3.3 years. Over three-quarters (76.1%) of study participants had less than a primary school education and the majority (84.5%) resided in rural areas. The vast majority of fistulas seen were uniquely urinary in nature (96.1%) and were obstetric in origin (97.8%). Just under one-third (29.5%) of fistulas were subjectively classified by providers as being "simple," 40.8% were classified as being "intermediate" and 29.7% were classified as being "complex." All participants received indwelling catheters post-surgery, with 79.1% having open drainage systems. Mean catheterization time was 19.5 days. Proportions of fistula closed at 3 months following surgery were 92.9%, 87.6% and 67.8% for simple, intermediate and complex fistula, respectively. Facility-level predictors of repair outcome will be presented.

Conclusion

The results of the study will help answer some of the most pressing clinical research questions in the fistula field, and will inform future interventions and further research in fistula treatment and prevention.

What strategic information for obstetric fistula
Quelles informations stratégiques pour la FO?

Luc de Bernis, UNFPA

The OF has gained a lot of attention during the recent past years, in particular from 2003, beginning of the Global Campaign to End Fistula. Recent evaluation has shown excellent progress in terms of awareness raised both at global and country levels, strengthening of obstetric fistula centers and training of surgeons, in particular. Still, however, we don't know how many women are suffering from OF, how many women are developing OF each year and, even more worrying, how many women living with fistula are actually receiving treatment within and beyond the Campaign, also the issues/?details/?quality of such treatment. We will not be able to measure the attainment of our objectives if we are not able to measure progress and show that we are reducing the number of women waiting for surgery. We will not be able to maintain attention from governments and donors if we cannot demonstrate an increased number of women treated and cured. Numbers are critical as they reflect the quality of the implemented strategies. The Global Campaign to End Fistula, with CDC, has identified the indicators we need to consider to document and analyse progress on Fistula treatment and socio-economic reintegration. In this specific issue, the role of surgeons and of OF centers managers is particularly important. The presentation will focus on the need for collecting information experiences and proposals to improve measurement quality at OF centers levels.

Why Quality of OF repair matters ?
L'importance de la qualité de la fermeture de la FO

Luc de Bernis, UNFPA

The goal of all fistula surgery is to close the fistula and to restore continence. OF is difficult surgery. Needs for repairs are huge. For all these reasons there is a need for (1) promoting seriously prevention strategies; (2) training more surgeons to staff equipped centers; and (3) establishing sub-regional and national training centers (including trainers' development), in order to increase rapidly the number of women treated. However, this will not be enough because quality matters. Quality should be associated to numbers and cannot be compromised. Therefore quality should come with quantity. Reporting on immediate and long-term post operation recovery is part of the treatment, even if this is still largely neglected. Indicators have been developed to address the quality of the surgery and the quality of life after surgery (CDC with the Global Campaign to end Fistula). But the quality is dependent on a number of factors which are addressed in this presentation.

Fistules vésico-vaginales en Afrique sub-saharienne : état des lieux, problématiques en santé publique et en aide humanitaire
VVF in Africa: The current state of affairs and issues surrounding public health and humanitarian aid

Béatrice Cuzin, Service d'urologie et de la Transplantation, GH E Herriot, 69437 Lyon Cedex, France.

But et méthodes

les auteurs se proposent de traiter le sujet en réalisant une analyse critique de la littérature sur les problématiques touchant la santé publique et l'aide humanitaire dans le domaine des fistules vésico-vaginales (FVV) afin des dégager des points critiques, des suggestions de réponse pouvant servir de trame à un groupe de travail.

Résultats et Discussion :

1- Etats des lieux

Une revue récente de la littérature (Zheng AX et al 2009) a permis de colliger les études disponibles afin de préciser les taux d' incidence et de prévalence de cette pathologie. Cependant plusieurs difficultés apparaissent : l'appréciation des taux de fistules vésico-vaginales globaux est difficile et les publication déjà anciennes. L'appréciation des taux de fistules obstétricales n'est pas non plus précise, même si une étude de grande envergure est en cours (UNFPA). Les difficultés de mesure ont fait préconiser certaines méthodes spécifiques comme la méthode des « sœurs » (Stanton C et al 2007). De même quelques chiffres sont disponibles sur le potentiel et les moyens des centres qui pratiquent la chirurgie réparatrice des fistules (Velez a et al 2007), même si la plupart sont fragiles.

2- Problématiques/enjeux en Santé publique

Peu de publications sont retrouvées sur les conséquences globales des FVV, la plupart des articles se contentant de décrire les « trous », même si l'exclusion de la « fistuleuse » de sa communauté et les mauvais traitements qu'on lui inflige sont connus. Les troubles psychologiques, les conséquences psychosociales, la mortalité périnatale, les taux de divorce ont toutefois été décrits par certains auteurs (Goh JT et al 2005, Ahmed S et al 2007, Muleta M et al 2008). L'incontinence post-opératoire, l'infertilité et les difficultés sexuelles, la réintégration, et surtout la prévention reste des domaines presque « vierges » de publications. Quelques pistes de réflexion peuvent être envisagées.

3- Problématiques/enjeux en aide humanitaire

Beaucoup de missions « fistules » sont basées sur la volontariat, elles sont ponctuelles et

financées par des ONG, même si pour certaines d'entre elles, la pérennité semble acquises la plupart restent fragiles et subissent divers aléas préjudiciables pour les patientes. Plusieurs problèmes méritent d'être développés celui de la formation des professionnels prenant en charge les patientes, celui des stratégies et structures de prise en charge, celui de l'éthique inclus en partie dans les deux précédents, celui du financement. Des pistes de réflexion seront également proposées pour l'ensemble de ces thèmes.

Conclusion

Actuellement dans la prise en charge des FVV, les objectifs doivent être de réunir la communauté des soignants, de développer des programmes de formation standardisés, d'améliorer le suivi et la réintégration des femmes atteintes de FVV, sans oublier les programmes de prévention, car cette pathologie peut être complètement prévue. Quelques sociétés scientifiques commencent à organiser des groupes de travail autour de ces priorités : ISOFS, AFU, FASULF, etc……

VVF Surgical Camp Outreaches the way to manage the VVF Patient Backlog : Experience of Mulago VVF Unit

Les camps de traitement de la FVV - la façon de prendre en charge les cas accumulés de FVV: L'expérience de l'équipe FVV de Mulago

Barageine Justus Kafunjo, Mulago Hospital, Kampala Uganda

Introduction

Globally there is an estimated backlog of fistula patients of about 2 million women. Despite global efforts, MDG 4 and 5 are still far from being achieved especially in Sub-Saharan Africa. In Uganda the MMR is 435/ 100,000 live births and for every mortality about 3 times the number of women will be left with severe morbidity of which fistula is one of the commonest in low income countries. In Uganda the ANC attendance (1st visit) is above 90% but deliveries in attendance of skilled birth attendant is only at 42 % and the rest deliver in villages under unskilled attendance if any. The Uganda demographic and health survey 2006 estimated a prevalence of 2.6 % among women. Mulago is the main centre in the country where routine fistula surgery is done in the Urogynaecology division but only 14 beds are available for this service where patients stay for average 18 days. Occasionally surgery is interrupted by other pressing issues in a government hospital like supplies, no anaesthetist and university calendar hence if every 3 weeks 14 patients are operated this leaves most of the patients on waiting list. The VVF patients are poor and hence cannot afford the transport costs along to the referral hospital. It was against this background that an outreach program was started to cover the catchment areas for this referral hospital.

Objectives of the program

To Screen and Repair VVF Patients, start CMEs for staffs in the unit on updates in fistula care. Provide support supervision to service providers in matters of safe motherhood especially prevention/management of obstetric fistula and obstructed labour. Interact with patients in matters of emergency obstetric care/safe motherhood especially ANC. Assess the community/heath service provider practices in issues of obstetric fistula prevention and care in form of operations research.

Methods/process

The heads of the units to be visited were contacted and patients mobilized FM radio announcements in the local languages. UNFPA, AMREF and MOH- Mulago hospital provided logistics in terms of transport for the surgeons, DSA, heath facility reimbursement for the expenses incurred, supplies and mobile kits. A team of 2 surgeons, one theatre nurse anaesthetist and driver would join the campsite staffs whatever the cadre. Patients were screened on the first day and surgeries would continue for 5 days. CMes would be provided especially on updates of fistula management and printed instructions left after five days for reference. Consultations would continue on the mobile telephones.

Results/ outreach Output

These included Number of outreaches conducted, patients screened and repaired, number of staffs attending the CMEs and the village/community meetings carried out. The detailed results will be presented. It was clear that in one week average of 40 fistula patients would be repaired compared to 7 patients that were routinely repaired in one week. The unit staffs were oriented in fistula management and now we have started training local teams to manage simple fistula and also be able to classify and refer difficult patients to Mulago. Patients have no limitations in transport costs. Details of the intervention will be presented including problems meet.

Recommendations

This model can be used to reach all areas in the country and even help to interest the future to be fistula managers. This also helps where human resource is limited since the one week outreach is labour intensive.

OF repair training in Benin
Formation au traitement de la FO au Bénin

Tamou Bio , Ignace d'Oliveira, Rene Darate, Serigne Magueye Gueye, Rene Hodonou, Akpo Cesar, Benin

Assessment of national and sub-regional obstetric fistula outreach campaigns
Bilan des campagnes nationales et sous - régionales de prise en charge chirurgicales de fistules obstétricales (FO)

Kalilou Ouattara, Service d'urologie, Unité de traitement des FO, CHU du POINT G Bamako, Mali

Introduction

Comme vous le savez la contrainte majeure à la mise en œuvre des stratégies, programmes et projets de prise en charge de la fistule obstétricale (FO) est l'insuffisance voir l'absence dans nos pays de chirurgiens nationaux qualifiés en la matière.
Pour pallier a cette situation en attention la formation des chirurgiens nationaux l'ISOFS peut mettre à contribution les campagnes chirurgicales FO.
L'équipe chirurgicale FO du Mali veut partager son expérience dans ce domaine tel est l'objectif de cette communication.

Matériels et Méthodes

De 2006 à 2010 l'équipe de traitement chirurgicale des FO du Mali a eu à animer 16 campagnes chirurgicales reparties comme suite

- Mali – 9 (Gao- 4; Tombouctou- 2 ; Ségou- 2; Hôpital du Point G-1)
- Mauritanie – 1
- Guinée Équatoriale – 1
- Cameroun - 1
- Liberia - 2
- République Centrafricaine - 2

Les campagnes sont organisée par le ministère de la santé des différents pays en collaboration avec l'UNFPA ou autres partenaires au développement (ONG nationale ou Internationale impliquée dans la prise en charge des fistules obstétricales.
Toutes les campagnes se sont déroulées en quatre étapes a savoir :

PHASE I Activités de sensibilisation d'identification et de recrutement des malades dans la communauté.
PHASE II Accueil et installation des malades dans la structure hospitalière identifiée.
PHASE III Arrivée et activités de l'équipe technique
PHASE IV Démarrage des activités médicales sur fond de counciling (consultions externes, bilans préopératoires et consultation pré - anesthésiques, traitement chirurgicale, suivi post-opératoire visites aux opérées, etc.)
PHASE V-Bilan global de la session et leçons apprises.

Au total 503 malades opérées dont 258 soit (51,3%) lors des campagnes nationales et 245 soit 48,7% lors des campagnes sous régionales. L'analyse des données socio-demographiques, administratives, et cliniques a encore une fois de plus confirmé ce qui est bien connu en matière de FO a savoir :

- Une majorité de malade venant de la campagne ou l'aide obstétricale qualifiée est insuffisant- 483 soit 96 % dans toute les séries.
- L'âgé jeune des patientes au moment de

l'installation de la maladie -20 ans

- Age extrême des malades et âgé extrême de la FO au de la de 50 ans preuve d'une longue souffrance et d'une longue endurance de la maladie.
- Une majorité de primipares 406 soit 80,7% sauf en RCA ou les multipares l'emportent- 61,5% des cas.
- Selon l'environnement 359 fistules sur vagin souple représentent soit 71,5 %, 107 fistules sur sclérose vaginale soit 21,5%, et l'association FRV et FVV – 37 cas soit 7,0%.
- Selon la localisation anatomique 266 fistules de type I soit 52,8% ; 77 fistules de type II soit 15,3 % ; 131 fistules de type III soit 26 %. 14 cas de fistules complexes soit 2,7 % et 15 cas de fistules iatrogènes hautes soit 3,2%.
- La voie d'abord est vaginale dans 453 cas soit 90 % et haute dans 50 cas soit 10%.

La réussite globale du traitement est 91, % -pour les fistules fermées sans incontinence urinaire (461 cas),7,5 % pour les fistules fermées avec incontinence

Conclusion

Notre expérience qui rentrent dans le cadre d'un partenariat sud – sud montre que les campagnes chirurgicales FO peuvent être une alternative a l'insuffisance de chirurgiens de la fistule dans les différents ou les malades sont obligées d'attendre d'hypothétiques campagnes annoncées par des chirurgiens expatriées. Cela par sa portée médiatique dans le pays la campagne a u n impact de sensibilisation au niveau des communautés, de plaidoyer au niveau de la société civile, des responsables administratives, politiques et sanitaires, auprès des partenaires au développement. La campagne est l'occasion pour le chirurgien de se mesurer et de s'auto- évaluer par rapport a la fistule obstétricale. L'ISOFS doit adopter cette approche.

Obstétricals fistula outreach activities in Senegal
Activités de Prise en charge des fistules obstétricales au Sénégal

Issa LABOU, El hadj Ousseynou FAYE, Sogo MILLOGO, Lamine NIANG, Kalidou KONTE, Mohamed JALLOH, Medina NDOYE, Jean Charles MOREAU, Serigne Magueye GUEYE

Les actions menées au Sénégal dans le cadre de campagne mondiale d'élimination des FO initiée par l'UNFPA peuvent se décliner en deux parties essentielles : la sensibilisation et la réparation des fistules constituées. Les campagnes de chirurgie qui ont surtout été une opportunité de formation des prestataires dans le but de pérenniser Les actions sont menées grâce à l'appui de l'UNFPA et une bonne collaboration entre le Ministère de la Santé et de la Prévention et l'Université Cheikh Anta DIOP par le canal des services universitaires d'urologie et de la Clinique Gynécologique et Obstétricale (CGO).

Les campagnes de sensibilisation ont été menées en direction des populations, des autorités politiques et décideurs tant au niveau national que celui des collectivités locales.

L'implication de la société civile et des ONG particulièrement l'Association InnerWheel a été suivie par la récente participation de IntraHealth et WAHA international a été un plus dans cette initiative.

Dans le cadre de l'élaboration de la politique de santé de la reproduction, il a été élaboré un plan stratégique de lutte contre les fistules avec l'implication des acteurs des niveaux central et opérationnel et des partenaires au développement impliqués dans le domaine de la santé maternelle. Cette stratégie tend à l'intégration des Fistules Obstétricales dans les Politiques Normes et Protocoles de SR.

La prise en charge chirurgicale des fistules obstétricales a consisté à une phase préparatoire et une phase d'exécution. La préparation a consisté à l'évaluation des besoins des centres de traitement dont certains ont été renforcés grâce à l'appui de l'UNFPA, à l'identification et l'orientation des femmes porteuses de fistule vers les centres de traitement avec l'implication des acteurs de santé mais aussi des relais communautaires et des groupements de femme.

Les séances de réparation, organisées autour de mission de terrain, ont permis de renforcer les capacités des personnels des services de gynécologie-obstétrique et de chirurgie des centres de traitements des hôpitaux régionaux. Des médecins « compétents SOU » dans la région de Tambacounda ont participé aux sessions de formation.

Leçons apprises

- La sensibilisation, souvent limitée aux campagnes de traitement, doit être maintenue au niveau des districts.
- La plupart des praticiens considèrent la cure de fistules obstétricales comme une chirurgie très complexe. Cette chirurgie qui reste encore l'apanage des « urologues » en milieu francophone intéresse de plus en plus les

gynécologues accoucheurs.

En perspective il faut renforcer les actions qui consistent à :

- valider et dérouler le plan stratégique, renforcer la sensibilisation au niveau national
- renforcer le partenariat entre acteurs et avec la société civile
- encourager et former les praticiens, particulièrement les accoucheurs, à ce type de chirurgie
- transférer des compétences aux acteurs de terrain afin d'assurer la prise en charge régulière des fistules dans les hôpitaux des régions voire des districts.
- renforcer la capacités des centres de traitement déjà identifiés dans chaque zone du pays et des centres nationaux de référence pour la chirurgie reconstructrice complexe et/ou les dérivations palliatives.
- développer des stratégies de réinsertion sociale des femmes opérées par la formation et par la facilitation de l'accès à des activités génératrices de revenus.

Experience in fistula outreach in Ngosi Burundi
Expérience de l'activité de prise en charge des fistules à Ngozi, Burundi

Flliberto Zattoni, Italy

OF outreach project in Abéché (Chad)
Projet de prise en charge des FO à Abéché (Tchad)

MSF (Geneva)

Use of HINARI/PUBMed for Evidence-based information on Obstetrical Fistula
L'utilisation du HINARI/PUBMed pour les informations fondées sur des preuves concernant la fistule obstétricale

Dr Mohamed Jalloh, Hopital General Grand Yoff, Dakar, Senegal

Socio-demographic determinants of obstetric fistula
Determinants socio-demographique de la fistule obstétricale

Mulu Muleta, Ethiopia

Introduction

Obstetric fistula often reported as a problem of poor, nulliparous young girls from destitute social background, however, insufficient observational studies confirming significant associations of these parameters with obstetric fistula formation. This article examines the level of association of these parameters with the development of obstetric fistula.

Methods

A multicenter case control study in Ethiopia investigated potential risk factors of obstetric fistula formation. Women with obstetric fistula admitted to the centers for fistula care were included and randomly selected controls that gave birth the last 3 years, however, without obstetric fistula complicating the birth were included as controls in the analysis.

Result

Data from 159 cases and 164 controls was analyzed and significant association observed between age at marriage (OR= 1.6), educational status (OR= 6.5), access to gravel road (OR =3.7), distance of patient home from the nearest hospital with cesarean section services (OR= 4.7) and patient stature. There was no significant difference observed between age at causative delivery, economic status and decision making power among the cases and controls.

Conclusion

Girls' education, delay age at first marriage and improving access to emergency obstetric care are essential interventions to reduce grave obstetric complications.

Risk factors of obstetric fistula : a clinical review
Facteurs risques de la fistule obstétricale: une revue clinique

Pierre Marie Tebeu, Joseph Nelson Fomulu, Sinan Khaddaj, Luc de Bernis, Anderson Sama Doh, Charles Henry Rochat, University Hospital, Yaoundé Cameroon

Introduction

Obstetric fistula is the presence of a hole between a woman's genital tract and urinary tract i.e. vesico-vaginal fistula or between the genital tract and the rectum i.e. recto-vaginal fistula. Better knowledge on risk factors for obstetric fistula could help in preventing it occurrence.

Objectives

The purpose of this study is to assess the current state of knowledge regarding the characteristics of obstetric fistula patients.

Methods

We conducted a search of the literature to identify all relevant articles published in the period 1987-2008 in the bibliographic databases.

Results

Among the 19 selected studies, 15 were from sub-Sahara Africa and 4 from the Middle East. Among the fistula cases, 79.4 to 100% are related to the obstetric conditions while the remaining cases estimated as less than 20% are from other causes. Among the overall fistula cases, recto-vaginal fistula represents 1 to 8%; vesico-vaginal, 79 to 100% of cases and combined vesico and recto vaginal fistula, 1 to 23% of cases.

Teenage condition found in a wide range in obstetric fistula patients ranging from 8.9 to 86 % of patients at the moment of management. The patient at the moment of the occurrence of fistula is at the first delivery for 31 to 66.7% of patients.

Among t.he obstetric fistula patients, 57.6 to 94.8% of women try the labour at home and are secondary transferred to the health facility. Finally 9 to 84 % of the patients have delivered at home (Table 6).

Many patients among obstetric fistula patients have less than 150 cm of height (40-79.4%) (Table7).

The mean duration of labour among the fistula patients range from 2.5 to 4 days. Twenty to 95.7 % of patients have been on labour for more than 24 hours. Finally, operative delivery will be performed for 11 to 60% of cases on indexed delivery.

Conclusion

Obstetric fistula is associated to several risk factors and they appear to be preventable. This knowledge must be use in strengthening the preventive strategy both at the health facility and at the community level.

Key words

risk factor, obstetric, vesico vaginal fistula, rectovaginal fistula.

Facteurs influençant les résultats des réparations de fistule dans les pays en développement: une revue systématique de la littérature
Factors influencing fistula repair outcomes in developing country settings : a systematic review of the literature

MSF (Geneva)

Background

A vaginal fistula is a devastating condition, affecting thousands of women across Africa and Asia. In light of the challenges involved with providing fistula repair services in developing countries, finding ways of providing services in a more cost-effective manner, without compromising surgical outcomes and the overall health of the patient, is of paramount importance.

Objectives

To conduct a systematic review and synthesis of the extant literature examining factors that may influence fistula repair outcomes in developing country settings, including fistula and patient characteristics, as well as facility-level factors, such as peri-operative procedures used and other aspects of service delivery.

Methods

We reviewed English and French language literature cited in the Medline database between 1970 and 2010. Titles of 2,437 articles were reviewed to determine eligibility, from which a master candidate list of 526 articles was compiled. Articles were excluded from the analysis if they were 1) case reports, cases series or contained 20 or fewer subjects; 2) focused on fistula in industrialized countries; and 3) did not statistically analyze the association between facility or individual-level factors and surgical outcomes.

Results

Sixteen articles (two randomized controlled trials and 14 observational studies) met the selection criteria. Less than one-third of the studies conducted rigorous statistical analyses. Patient and fistula characteristics were more frequently studied than facility-level factors such as peri-operative procedures. Evidence to support the role of age, parity, duration of leakage, and mode of delivery on repair outcomes was weak, and in the case of parity, contradictory. In terms of fistula characteristics, there is relatively strong evidence to support an association between negative repair outcomes and the presence of vaginal scarring, greater fistula size and small bladder size. Studies had contradictory findings with regard to the association between urethral involvement and fistula repair outcomes, and evidence was insufficient regarding the influence of ureteric involvement and prior repair on repair outcomes. While the majority of studies examining the influence of facility-level factors on repair outcomes were inconclusive, a small body of evidence suggests lack of a beneficial role of Martius Flap interpositioning with regard to repair outcomes.

Conclusion

Despite a growing number of empirical studies examining the relationship between surgical outcomes and both patient and fistula characteristics and peri-operative procedures used, there remains a lack of a unified evidence base on which to base practice. Further research is urgently needed to improve the care and treatment of this most marginalized and neglected group of women.


Obstetric Fistula International Conference
ISOFS 2010
December/Décembre 7 - 9, 2010

IFRU

Institut de Formation et de Recherche en Urologie

Telephone: +221-338273819
www.ifru.org

Coordonateur : Pr Serigne Magueye GUEYE

L'IFRU (Institut de Recherche et de Formation en urologie) a été fondée a Dakar en 2004.
Principales missions sont :

- De promouvoir et de mettre en œuvre la recherche et la formation dans tous les domaines de l'urologie et de la santé familiale notamment en matière de santé sexuelle et reproductive
- De développer la formation et la recherche dans les maladies tropicales négligées
- De mettre en œuvre, de réaliser et /ou de promouvoir toutes recherches, en santé publique notamment toutes recherches biomédicales, épidémiologiques, pharmacologique dans le domaine de l'urologie et/ou de la chirurgie en situation précaire
- Informer et éduquer les populations dans un but de prévention et/ou de détection précoce des maladies urologiques en général et des cancers génitaux et urinaires en particulier.

L'IFRU est organisé en centres d'activités :

- CENTURO : Centre des nouvelles technologies en Urologie
- CAMS : Centre d'Andrologie et des maladies sexuelles
- CIRFO : Centre international de recherche et de Formation sur les Fistules Obstétricales
- CEBM : Centre de Evidence Based Medicine

L'IFRU s'est particulièrement distinguée dans la formation sur l'endoscopie du bas et du haut appareil urinaire en collaboration avec la firme Karl Storz à l'intention des urologues du Sénégal et d'autres pays d'Afrique mais également en assurant le volet formation et réparation des fistules obstétricales au Sénégal mais aussi dans d'autres pays d'Afrique de l'Ouest, du centre et de l'Est.

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HOPITAL GENERAL DE GRAND-YOFF

AU COEUR DES POPULATIONS UN HOPITAL POUR LA VIE

L'hôpital général de grand yoff est un établissement public de santé de niveau 3.Il est implanté dans la commune d'arrondissement de grand yoff. L'hooggy correspond a l'ex centre de traumatologie et d'orthopédie, construit par la caisse de sécurité sociale et cédé à l'Etat, en 1995. L'établissement est très accessible en raison de sa proximité avec l'autoroute. Il est doté d'une personnalité juridique et d'une autonomie de gestion. Sa capacité d'accueil est de 300 lits. Sa vocation est à la fois nationale et sous régionale. L'établissement dispose d'un magnifique cadre infrastructurel. Son plateau technique est très relevé. En plus de l'orthopédie traumatologie, l'hoggy a diversifié ses activités. Désormais ouvertes vers les disciplines de spécialités médicales et chirurgicales. Dans ce paquet de services on retrouve dans son dispositif, les services de cardiologie, de médecine interne, d'urologie -andrologie, de gynéco obstétrique, d'ORL, d'ophtalmologie, d'odonto -stomatologie, de réanimation et de chirurgie générale. A ce dispositif s'ajoute des services médico -techniques : un bloc opératoire (9 salles) , un service d'exploration cardiaque et endoscopique, une imagerie médicale, un laboratoire de biologie et d'ana pathologie, un service de consultation externe, une unité de médecine nucléaire dotée d'une gamma camera, un service kinésithérapie et un service des urgences. Puis, d'importantes acquisitions d'équipement ainsi que de réalisations sont en cours de finalisation. Il s'agit plus précisément d'un générateur d'oxygène pour l'autonomisation de l'hôpital en gaz médical, d'une construction d'unité de traitement des déchets biomédicaux, utilisant une technologie non incinératrice, de projet d'un service de gynéco- obstétrique et pédiatrique communément appelé « pôle mère-enfant « et d'un nouveau service d'accueil des urgences (SAU).
A ce propos, il importe de noter que les praticiens de la structure sont tous spécialistes. Aussi, plusieurs universitaires y officient également. Enfin, l'hôpital général de grand yoff se distingue par la jeunesse et que la compétence de son personnel.