

Early breakdown of fistula repair after discharge. Is it really a problem?

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Introduction

One of the most distressing findings in fistula surgery is to see a patient who was discharged home apparently dry, only to see her again with the story that she became wet soon after leaving hospital. Out of a consecutive series of 756 patients said to have been discharged home dry after fistula repair from three hospitals in Uganda, 16 were identified as having become wet soon after discharge, either on the way home or within one or two weeks.

This short account summarises our experience and suggests some possible causes and solutions where feasible.

Possible causes and solutions

1. They were not really dry, were impatient to leave and may have misled the nursing staff on purpose. A very small number confirm this but are not included among the 16.

Solution: Ideally everyone should have a dye test before removal of the catheter. If unexpectedly positive the catheter should be kept in for longer. Unfortunately for practical reasons it was not routine practice to perform a dye test before removal of the catheter in this series.

2. They went home with unrecognised chronic retention which predisposed to breakdown.

David Lyth and Alyona Lewis in Freetown¹ have shown that in a third of patients the bladder did not empty adequately immediately after catheter removal

and one week later, 15% still had significant residuals and were sent home performing intermittent self catheterisation. Without routinely measuring residual urine it seems a significant number may be sent home with a degree of chronic retention. We know that one of our early breakdown patients developed retention and was treated with an indwelling catheter for a week but then sent home without checking her residual urine again. It may well be that chronic retention does predispose to early breakdown.

Solution: Patients should not be allowed home with a residual of more than 100mls without a further trial after catheter drainage or learning and performing intermittent self catheterisation as needed.

3. Over distension of the bladder on the way home. Many patients have long and arduous journeys home. One patient told us that she got a very full bladder but was too shy to ask the taxi driver to stop to empty her bladder and soon after became wet.

Solution: Patients should be warned of this risk. It is unlikely that they will be able to stop to void and a very good suggestion from Dr Barageine in Kampala is that the patient should go home as they came, i.e. wet. They should pad up before the journey and pass urine as they travel if necessary.

4. Early resumption of sexual activity in spite of contrary instruction. Only one patient has admitted to this. But this may be a factor in others.

Solution: We strongly advise against intercourse until

she has been for a follow up examination.

5. Early resumption of physical activity. Some women have admitted that wetness returned after heavy activity. This may be a factor which would be hard to prove but difficult to avoid in some cases for economic reasons.

6. A late wound infection.

It is well known that wound infections after other surgical operations can reveal themselves after the patient has been discharged and fistula operations may be no different.

7. The repair has not been very well done.

There was no bias towards beginners operations in our series of patients.

Clinical features

Perhaps surprisingly almost all the repairs were relatively simple ones, the recurrence being almost always a small defect and amenable to a re-repair. All our patients have had a second repair and 14 out of 16 were recorded as going home dry. The implication of this finding is that a small defect would almost certainly have healed if they had returned and submitted to a further period of catheter drainage.

Since becoming aware of the problem we have given our patients written and verbal instruction to return at once, but not a single one has done so. This is probably a travelling and financial issue and difficult to address. We also advise our patients to wait a week before setting off home to be sure they are not developing retention by simple questioning and abdominal palpation, but again they rarely comply.

Working as a visiting surgeon does not allow us the opportunity of supervising the discharge period, and post operative care may be sub-optimal due to shortage of nursing and medical staff. Thus, dye tests and measurement of residual urine have been impossible to do.

Though our recorded incidence of early leakage post discharge is small (2%) we suspect it might be higher as earlier in our experience we did not question our failed patients in detail. We are not alone in having recorded this

problem as Andrew Browning in Barhadir Ethiopia recorded early breakdown in 6 out of 141 patients said to be cured at discharge. ²

Conclusion

We believe this problem to be under reported or not recognised and encourage others to record their experience.

The most important message is that we suspect that in almost all of these patients the leakage was either avoidable and/or would have been cured by conservative management if only they had returned immediately.

References

1. Lyth D, Lewis A. Intermittent catheterisation after obstetric fistula repair. Presented to the International Society of Obstetric Fistula Surgeons (ISOFS) meeting Nairobi, 1999.
2. Browning A, Member B. (2008) Women with obstetric fistula in Ethiopia: a 6-month follow up after surgical treatment. *BJOG*;115:1564–1569.