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CASE REPORT

Vault fistula after caesarean hysterectomy may be confused with Asherman syndrome

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ABSTRACT

Complications are possible in all type of surgeries including caesarean hysterectomy irrespective of the experience of the operating surgeon or the presence of associated risk factors. If the surgeon is careful from the beginning of the surgery and follows all the preventive measures complications like urinary tract injuries and vesico-vaginal fistula formation following caesarean hysterectomy can be avoided. Here we are presenting a case of vesico-vaginal fistula with an intrauterine contraceptive device (IUCD) in the urinary bladder formed following caesarean hysterectomy. A 35 years old women P_2L_1 with history of 10 years of amenorrhea & continuous involuntary leakage of urine after LSCS attended gynaecologist who inserted a copper-T (Cu-T) through the vault fistula. The rent in the vagina looked like a flushed cervix in a perimenopausal woman.

Keywords: Vesicovaginal fistula, Cu - T, Asherman syndrome.

Vesico-vaginal Fistula (VVF) is defined as an abnormal communicating tract extending between the bladder (vesico-) and the vagina resulting in uncontrolable, involuntary leakage of urine into the vagina [1]. Obstetric fistula is a disease of developing world whereas in developed world it occurs after hysterectomy and other gynaecological surgeries. It is estimated that there are at least two million women living with fistula primarily in sub- Sahara Africa and South Asia and some 50,000-100,000 women are affected each year[2, 3]. In the United States and the United Kingdom, for example, 70% of fistulae are sequelae of pelvic surgery, which is in sharp contrast to the statistics in India, where 83% to 93% of fistulae are caused by obstructed or prolonged labour [4]. Vesicovaginal fistula (VVF), commonly caused by prolonged obstructed labor, is one of the worst complications of childbirth and poor obstetric care in the developing world. This unpleasant complication leaves affected women with continuously leaking urine, excoriation of vulvas and vagina, often rendering them social outcasts [5-7].

Case Report

A 35-year-old woman, P_2L_1 had symptoms of a VVF and continuous leakage of urine and amenorrhoea for 10 years, after caesarean hysterectomy. She consulted a gynaecologist who put a Cu-T through the

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vault fistula on March 2014 thinking the case as an Ashermans syndrome. The woman then consulted one general surgeon who sends her to Fakhruddin Ali Ahmed Medical College Hospital (FAAMCH). On examination – her general condition is fair. Speculum examination reveals leakage of urine through a rent in

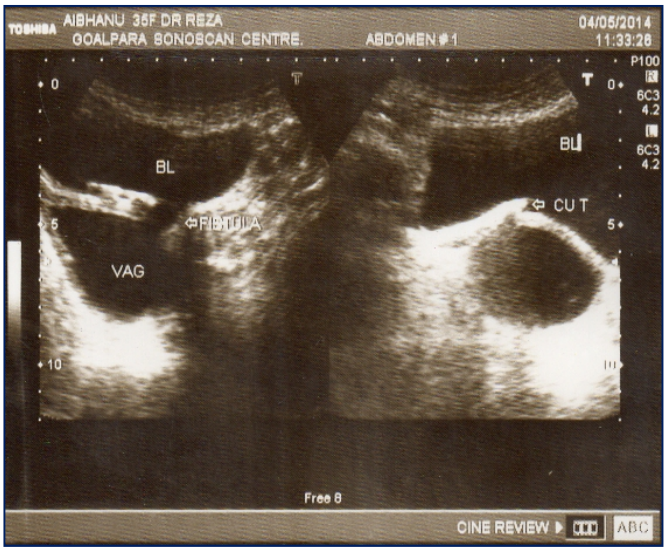

Figure 1: USG showing Cu-T inside urinary bladder

the vaginal vault. Ultrasography (USG) of lower abdomen reveals small uterus, vesico-vaginal / vesico – cervical fistula and Cu-T in urinary bladder. Intravenous pyelogram (IVP) confirms the diagnosis.

Extraperitoneal transvesical repair of VVF planned. On cystostomy Cu -T was seen in the urinary bladder and removed. Tripple layer closure of fistula was done. Two ureteric catheter were inserted with no 6 infant feeding tube. One suprapubic and one transurethral catheter were also kept. Postoperatively prophylactic antibiotic was given for 5 days. Ureteric catheter was removed on 8th postoperative day, suprapubic catheter on 15th and urethral catheter on 22nd postoperative day. Patient was discharged on 23rd postoperative day after successful passage of urine without any leakage.

Discussion

The literature reveals volumes of research articles, case reports, on VVF. But VVF with an IUCD within the urinary bladder is very hard to find out exact incidence of VVF after caesarean hysterectomy is not known. The leading cause of VVF was obstructed labor, which is 59.5% as reported by Singh et al [8] from India. After suspecting a VVF a thorough vaginal examination should be performed to identify its size and location, especially in relation to the trigone and eliminate an ureterovaginal fistula which can be associated in up to 10% of cases. Numerous methods for the treatment of vesicovaginal fistulae have been described. Abdominal, and vaginal approaches are used for the repair of vesicovaginal fistulae. The approach selected is dependent on many factors, but is probably best determined by the experience and training of the surgeon [9]. Management of these fistulas has been better defined and standardized over the last decade [10]. Extra uterine migration of copper-T, an intrauterine contraceptive device (IUCD), is well reported in the literature. In most cases, it is a chronic form of migration to the nearby structure [11]. Visceral migration to bladder, rectum, sigmoid colon, caecum, appendix, small bowel, and iliac vessels has also been reported [12]. But in this case IUCD was inserted into the bladder through the cicatrised rent in the vagina of a VVF occurred after caesarean hysterectomy.

Conclusion

Vesicovaginal fistula is still a serious iatrogenic consequence and causes suffering in the physical, emotional and social functioning of patients. A comprehensive approach will work best in preventing VVF in a developing country such as India. The problems of fistula, both medical and social, are likely to persist until better healthcare reaches the poorest and most vulnerable members of society. A thorough examination, specially triple swab test with methylene blue is very helpful to diagnose VVF otherwise it may be mistaken as Asherman syndrome like this case of vault fistula developing after caesarean hysterectomy presenting with amenorrhoea.

Conflict of interest: None. **Disclaimer:** Nil.

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