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EDITORIAL

Vaginal cystostomy - its relevance in gynaecology

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Urinary bladder along with urethra and the ureters are always of great importance to the gynaecologists. This is because of their strategic anatomical relations with the adjacent internal genital organs and the vagina. Many a time, urinary bladder is inadvertently injured and at other times we have to open it for facilitating some procedure or to do a repair. Whenever the urinary bladder is repaired, it needs rest postoperatively for healing. This needs a continuous drainage via a catheter. Though there are ways like suprapubic or urethral catheter drainage; another useful option of continuous drainage is by putting a catheter vaginally which is known as vaginal cystostomy[1]. There are very few studies in the literature regarding vaginal cystostomy. Though there are number of studies on extraperitoneal cystostomy in gynaecology[2].

Indications

1. Reconstruction of absent urethra.
2. Repair of VVF involving bladder neck.
3. Excision of urethral diverticulum.
4. Post operation complication of VVF repair viz blood clots in the bladder.

Procedure

Usually done under regional or general anaesthesia; but in dire necessity can be done under local anaesthesia. Site of operation is mid vaginal area (i.e., the middle third of anterior vaginal wall high up corresponding to the base of the bladder, above the interureteric bridge (Figure 1). The area is selected by indirect guidance with a uterine sound in the urinary bladder or a cystoscope, preferably avoiding the trigone area. Fixed the area by two tissue forceps on vaginal wall. A sharp incision is made here to open the bladder just to pass the foley's catheter (14 F size) and balloon inflated by 5mL. The catheter is anchored on the perineal skin. This is connected with an urine bag and output is observed carefully. Catheter is kept patent by intermittent syringing with normal saline if necessary. This is kept 10-14 days depending on the situation.

Advantage

This procedure does not need much difficult position or massive tissue handling. It needs little time in expert hand. It may be done under local anaesthesia. Most important is that it does not affect the urethra. Abdominal drainage for suprapubic cystostomy can be avoided. Advantage of gravity drainage on recumbent position is also present in this method.

Limitations

Only in selected indications it may be used. In vesico vaginal fistula (VVF) repairs, mostly involving base of the bladder and trigone, this can not be employed. Technique though simple, needs expertise and good anatomical understanding.

Discussion

The Author himself used this method in five different cases during a period of 20 years, from 1998 August to 2018 August while managing urinary fistulas, complications related to it. Out of these, two cases were of absent urethra following obstructed labour where neourethra was constructed. Two different cases due to post operative complications of transvesical VVF repair, where there was intravesical clot retention. Out of these two cases, one was done under local anaesthesia. One case was done in a case of rupture of bladder following rupture uterus repair, where there was clot retention.

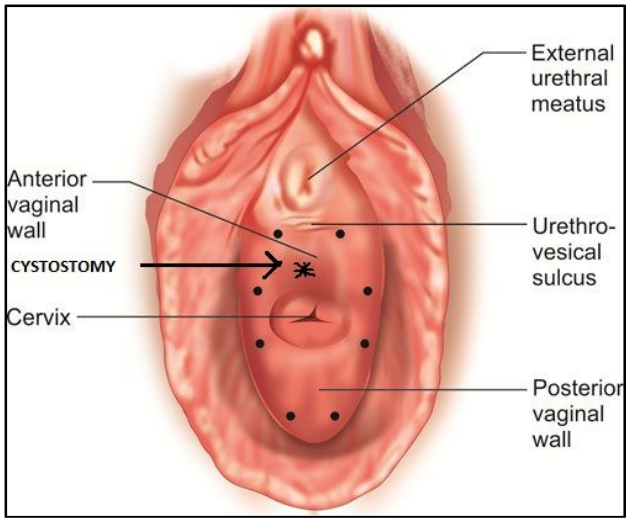

Figure 1: Site of cystostomy

Clot lysis could not be completed with cystoscope [3]. There is no relevant data available on searching the contemporary literature for comparison.

Conclusion

The study needs to be continued in large number of patients in different centres to validate the method further. It appears to be a simple, effective, less traumatic procedure in selected indications. Limitations of the procedure are that it needs proper training to acquire the proper skill.

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

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