Peri-operative care of fistula patients is vital to their successful management as it is for other surgical patients.

- Pre-operative care aims at optimising their general state of health before repair.

- Post-operative care - critical to the successful outcome of the repair; it minimises the risk of postoperative complications.
The ideal situation where all the facilities for the care of the simple fistula patients are available rarely exists in developing countries.

No unanimity of opinion on optimal perioperative care of fistula patients.

Because of the poverty of fistula patients, carers tend to be concerned about cost. They do only what is absolutely necessary for these patients in order to keep costs down.

Diagnosis

- History
- General Examination
- Vaginal / Speculum Examination
- ± Methylene blue dye testing
- Investigation any concurrent disease
Investigations

- Full blood count
- Sickling test as appropriate
- Blood grouping and save serum
- Blood urea and electrolytes
- Urine microscopy & culture
- Intravenous urogram
- Cystoscopy
- Examination under anesthesia

PRE-OPERATIVE CARE

- Preoperatively, the surgery for the particular fistula has to be planned.
- If the patient is malnourished or anaemic - Investigate
  - Offer nutritional advice and support
  - Prescribe iron, folic acid and vitamin tablets where indicated.
Offer psychological support - she is assured that the fistula is essentially curable, certainly preventable and not due to a curse or punishment from God.

- Its cause and prevention are explained.
- Antibiotics are prescribed in cases of recent fistulas following obstructed labor, urinary tract infection and bladder stones.

**Other measures**

- Ensure good hydration
- Skin care in the form of vaseline pomade or zinc oxide cream application to the vulva and perineum to treat the excoriations and ammonia dermatitis
- All usual preoperative checks are done.
**POST-OPERATIVE CARE**

- Optimal post-operative care requires a team approach with the surgeon, the nursing, and counselling staff as well as the patient participating.
- Postoperatively, regular checks of vital signs continue until patient is stable.

- The bladder is catheterised at the end of surgery (trans-urethral or by suprapubic cystostomy)

- Continuous bladder drainage of high-volume urine is the bedrock of success in fistula repair. This is done for 14 days.
- It enables the bladder repair to heal without distension and reduces the risk of infection and breakdown of the repair.

- Adequate hydration is ensured initially with intravenous fluids and then orally, aiming for a minimum intake of 3-4 litres daily.
A strict input/output chart is vital for monitoring.

- The patient is also instructed to report immediately if the catheter is not draining. The bladder is either irrigated or the catheter changed.

- A catheter specimen of urine is sent for culture and sensitivity if indicated.

- Limited bed availability and ward space often means some patients lie on the floor.

Day 4 postop. patient given up her bed
- Feeding is resumed within 24 hours of surgery

- Chest physiotherapy and leg exercises are encouraged.

- The vaginal pack (if used) is removed after 24 hours. Some carers keep the vaginal pack longer fearing that earlier removal might cause bleeding.
Perineal care - (swabbing and vaseline application) at least once a day.

The graft site dressing (if a graft is used to support the repair) is removed after 24 hrs.

The graft site sutures are removed after 5 days.
- If ureters are catheterised during the surgery the catheters could be removed at the end of surgery

- Some surgeons do retain the ureteric catheters for 3 to 10 days to ensure that all inflammatory reaction had settled before their removal.

- If the surgery was re-implantation of the ureter into the bladder, then the ureteric catheter in maintained for 7-10 days

- If the patient is dry, the catheter is removed after 14 days of continuous bladder drainage.

- If urine continues to leak, the catheter is maintained for a further 1-2 weeks.

- Longer catheterisation may increase the chance of further healing and closure of fistula.

- Following the removal of the catheter, one may assess for stress incontinence, infection, or hematoma at the graft site.
- Administration of prophylactic antibiotic is controversial. A single dose intravenous antibiotic is a common practice although not evidence-based.

- There is no evidence to show that longer courses of antibiotics are beneficial except in overt cases of infection.

- Postoperative oral iron, folic acid, vitamins and simple analgesics are usually the only medications required.

- Bladder re-training may be required in some selected cases i.e. in urgency, urge incontinence

- Urinary tract infection must be excluded
The patient is counselled to avoid sexual intercourse for three months to allow full recovery.

- The cause of fistula – explained.
- The need for caesarean section in subsequent pregnancies is stressed.
- Counsel on the loss of her child, husband, reproductive ability, livelihood, self-esteem and social status.

Most units that perform fistula repair do not have a formal counselling set-up.

- Counselling is therefore done by the doctors and ward nurses.
- Counselling must involve husbands if available. Husbands are usually absent.
- On discharge the patient must be given a card with her case summary and a recommendation for C/S in the future.
In summary, optimal perioperative care of obstetric fistula patients is crucial in the successful management of this dreadful disease. Some needs and problems do remain however.
Needs / Problems

- Need for a set-up for the resettlement of the cured fistula patients back into their communities.

- Can the duration of bladder drainage be reduced from 14 to 10 or 7 days? What is the optimal duration of bladder drainage postoperatively?

Needs and Problems

- Why are fistula patients not seeking care early? Some are seen many years after the start of the disease.

- “Inoperable fistula” patients are a humbling and distressing experience for patients and carers. What can be done for them that is culturally acceptable?

- Some answers to these problems should go a long way to help these patients.
Thank you