

## A CASE OF SEVERE VESICOVAGINAL FISTULA TREATED BY URETEROCOLIC IMPLANTATION.

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SEVERE cases of vesicovaginal fistula are now, thanks to modern obstetric methods, a rarity in civilized countries.

In India, however, despite the excellent work and propaganda of civil and mission hospitals in the larger towns, there still remains a vast population yet in the dark ages of medicine. The unfortunate mother in obstructed labour will usually be treated by the village midwife. After an unsuccessful attempt at manual extraction such well-tried devices as packing the vagina with cow manure and rolling large and heavy stones over the abdomen may be tried. That any such patient ever survives to reach a hospital is a miracle. If more fortunate she will be taken to a practitioner with some Western training and delivered after much unskilled instrumentation. These are the cases that provide the examples of severe vesicovaginal fistula common throughout India.

The surgeon, faced with a severe and probably long-standing vesicovaginal fistula, must consider three possible courses:—

- (1) Leave the patient in her misery, physical and mental.
- (2) Attempt a closure of the fistula. The chances of success here depend on the size of the opening between bladder and vagina, its duration, and the amount of scar tissue present. The region is always grossly infected, and an unsuccessful attempt at closure leaves the patient worse off than ever.
- (3) Attempt a ureterocolic implantation. As an alternative to an attempt at closure in doubtful cases this is in my mind the treatment of choice, as the operation is reasonably safe, not unduly difficult, and the immediate result in the case to be described was excellent.

### CASE REPORT.

The patient, a Hindu woman, aged 25, was first seen at the King Edward Memorial Hospital, Secunderabad, in January, 1939. She gave a history of difficult labour (her first pregnancy) about seven years ago, in which forceps had been used. The child died. Since then she has had continuous dribbling of urine with dyspareunia and dysmenorrhœa. Attempts at intercourse, which was now impossible, caused great pain. She had heard about the hospital in Secunderabad and decided to come in from her village to see if she could be cured.

*Examination.*—She was a well-nourished young woman otherwise sound. Pelvic examination revealed marked cicatricial stenosis of the vaginal outlet which admitted the tip of the index finger only. The little finger

could, however, be introduced up to the second joint, and a large opening between bladder and vagina detected, the tip of the finger just reaching the upper vaginovesical partition. The scar tissue formed a dense ring as hard as cartilage. There was continuous dribbling of urine from the orifice.

It was at once decided that she was inoperable from the point of view of any attempt at repair, and that a ureterocolic implantation offered her the only hope of future comfort.

*First Operation.*—Right ureterocolic anastomosis using a minor modification of Coffey's method was performed on February 2. The abdomen was opened by a mid-line subumbilical incision, the table tilted, and the intestines packed off. The right ureter was exposed as it crossed the pelvic brim, freed down to about  $\frac{3}{4}$  inch from the bladder, divided here and the distal end tied and the peritoneum then closed. This left about 3 inches of the ureter for implantation. The ureter was then implanted into the right posterior wall of the pelvic colon, just above the rectum, by Coffey's method, and the ureter buried for about  $1\frac{1}{2}$  inches in the bowel wall with Lembert sutures. The abdomen was closed and the patient put on free fluids and a urinary antiseptic.

Convalescence was apyrexial and uneventful, and the patient allowed up after fourteen days. There was no noticeable change in the amount of urine dribbling, but her motions were now mixed with urine.

*Second Operation.*—This was performed three weeks later and the left ureter similarly implanted into the left side of the colon posteriorly at a slightly higher level. The right anastomosis on inspection was completely satisfactory.

The patient was again put on free fluids and a urinary antiseptic, and again convalescence was apyrexial and uneventful. Dribbling of the urine *per vagina* of course ceased at once. Urine at first drained freely from the anus, but the rectum rapidly became tolerant to it and sphincter control returned, so that by the time of her discharge from hospital three weeks after the second operation, she could retain her urine about three to four hours. Her sphincter control became very good and she had no trouble in retaining it.

Pelvic examination prior to discharge showed that the vaginal outlet had become much softer and now admitted two fingers by which the bladder and vagina could be explored.

The patient returned to her village delighted with the result; in fact the remarkable change in her general mental outlook after the second operation was one of the most gratifying features of the case.

#### DISCUSSION.

The immediate result in this case left nothing to be desired, but of the ultimate prognosis one must be more cautious. The textbooks say that the danger in such cases is that an ascending ureteric infection is likely to occur sooner or later, but as most examples would appear to be based on

the experience of the similar operation for ectopia vesicæ and the two are not quite comparable, it is difficult to make a prognosis. In this case the woman returned to her village and was told to report again in three months. This she is most unlikely to do if she is feeling well. Shortly afterwards I was transferred to another station, so I shall never hear of her again.

In conclusion I would say that in my opinion the excellent immediate result justified the operation, and I see no reason to be pessimistic about the remote results.

I wish to express my thanks to Lieutenant-Colonel R. F. D. MacGregor, M.C., I.M.S., late Residency Surgeon, Hyderabad, for his permission to send these notes for publication and for his kindness in giving me facilities to operate on this and other cases at the King Edward Memorial Hospital, Secunderabad.

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## Echoes of the Past.

### TWENTY YEARS AFTER.

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(Continued from p. 380, No. 6, vol. lxxiii.)

#### II.—GUNSHOT WOUNDS OF THE CHEST.

CASE 10.—Hæmothorax from Wound of Subclavian Vein.

*Clinical History.*—Nature of wound: Gunshot wound, chest.

Signs and symptoms: Struck on chest. Wound leading to comminuted fracture of the right clavicle; no exit wound. Temperature 97° F. on admission, later in the day 101° F., pulse 110. Next day signs of left hæmothorax. Temperature 103° F., pulse 110, respirations 56 to 66; is very distressed. Next day spitting up blood-stained sputum; not offensive. Temperature 101° F., pulse 110, respirations 40. Thought to have a small hæmothorax and apical pneumonia. Next day temperature 100° F., pulse 106, respirations 42. Apex beat one and a half inches outside nipple line. Next day very dyspnoëic; temperature sub-normal. Died.

Operation: Wound excised under local anæsthetic.

Survival: About ninety-six hours.

*Post-mortem Result.*—Chest: Comminuted fracture of the right clavicle with a wound of the right subclavian vein. The right pleura absolutely full of blood, thin, not clotted. Upper lobe of the right lung was solid, very dark red in colour (? red hepatization or concussion hæmorrhage); the rest of the lung collapsed. Left lung a little congested.

Pathological report: Section of portion of the upper lobe of the right lung shows extensive hæmorrhage in the lung tissue, the cause of which is