Figure 2. Fourth-degree tear frontal view.
Figure 3. Dissection and grasping the end of the torn sphincter with Allis forceps.
Figure 4. Rectum/anus repaired and the sphincter sutured together.
Figure 5. Cross-section of a simple vesicovaginal fistula.
Figure 6. Vesicovaginal fistula (vaginal view).
Figure 7. Identification of the ureters. If possible, this should be done before dissection occurs; however, sometimes when the ureters are deep inside they become apparent when the bladder is mobilised, making access easier.
Figure 8. Adequate mobilisation.
Figure 9. Repaired fistula with inserted Foley catheter.
Figure 10. Cross-section of a simple rectovaginal fistula.
Figure 11. Digital examination of the anus drawing the rectovaginal fistula forward and into view.
Figure 12. Dissection completed.
Figure 13. Rectovaginal fistula closed.
Figure 14. Cross-section of a vault vesicovaginal fistula.
Figure 15. Fistula mobilised and sutures placed through the detrusor muscle of the bladder.
Figure 16. A vault fistula as seen via a laparotomy. A cystotomy has been done and the fistula can be seen.
Figure 17. The cystotomy has been extended to the fistula (O’Conor method ). The bladder needs to be dissected off the cervix/vagina before both can be repaired.