

Level 2 Module 5 Circumferential Vesicovaginal Fistula

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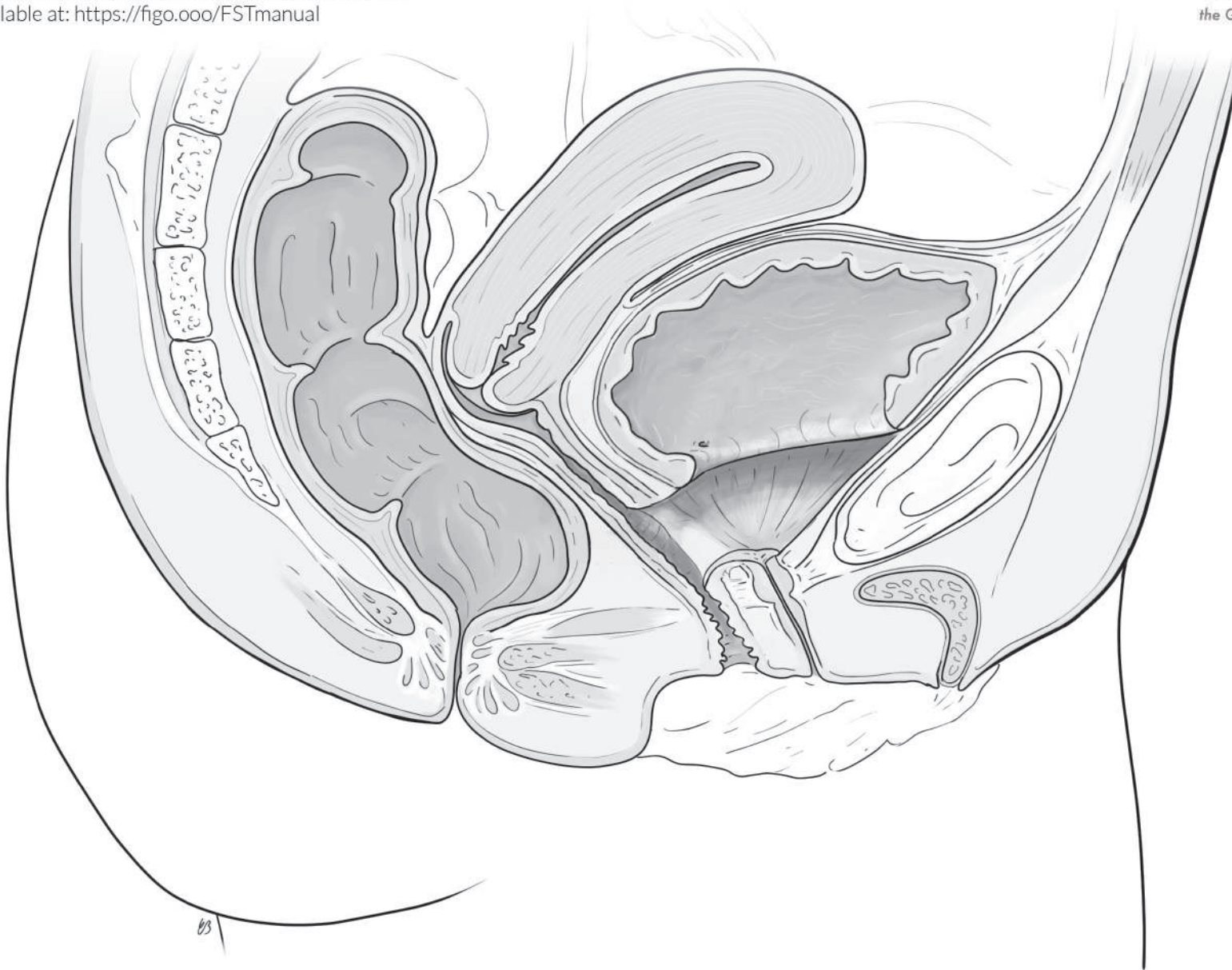


Figure 18. Cross-section of a circumferential vesicovaginal fistula.

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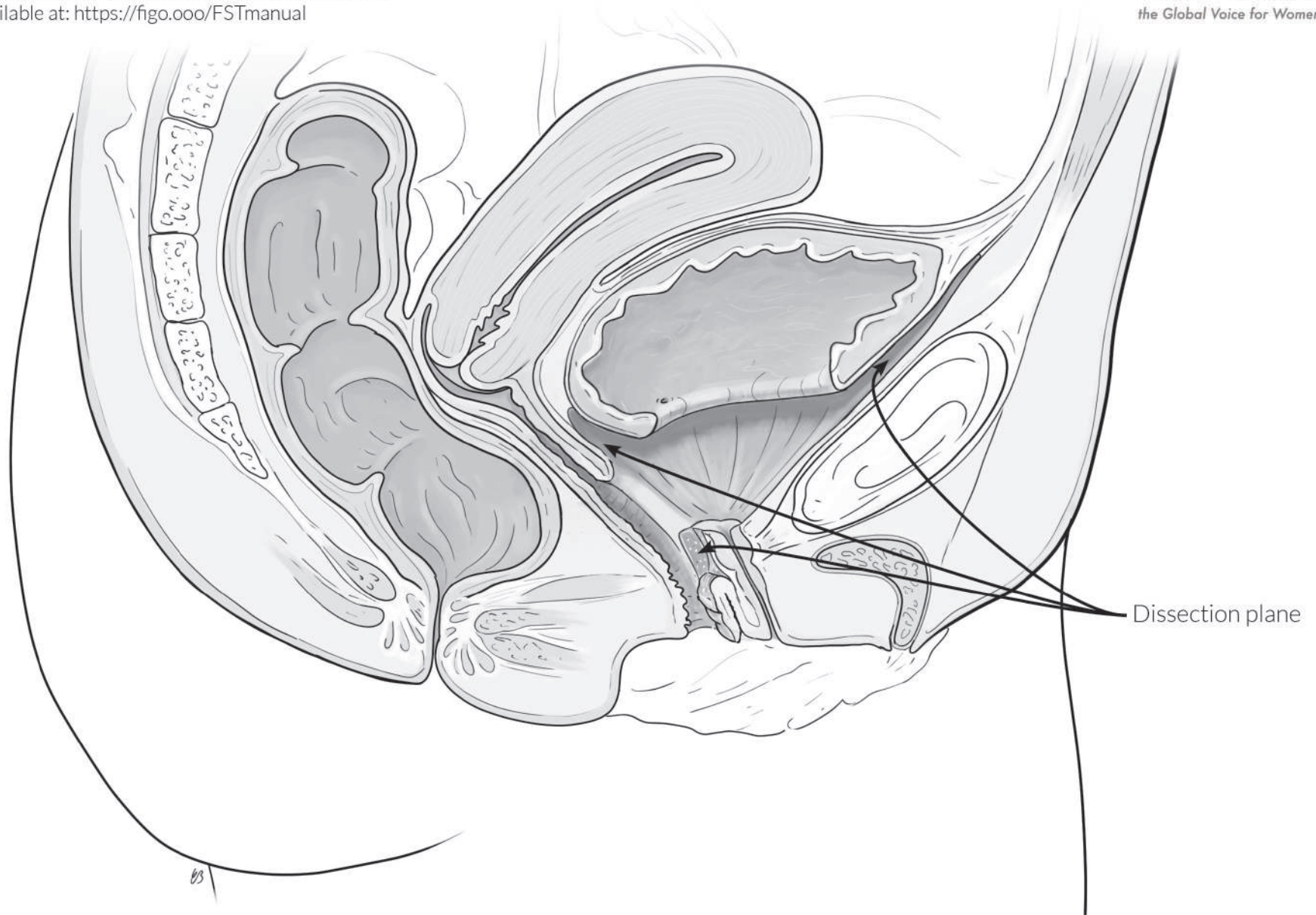


Figure 19. Mobilisation of the bladder circumferentially from the vagina and pubic bones. Distally the vagina has been reflected off the remaining urethra.

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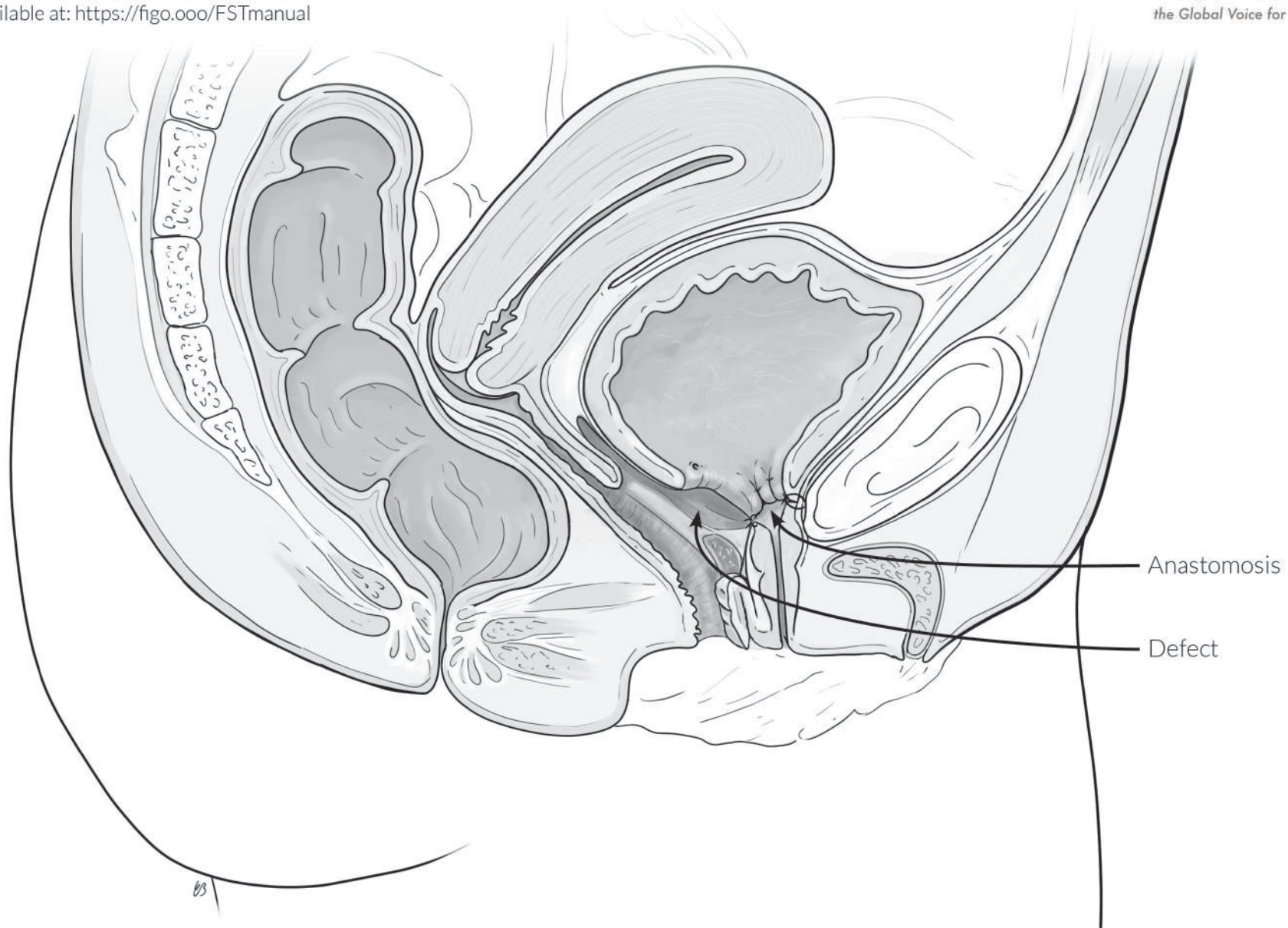


Figure 20. The bladder is anastomosed to the urethra anteriorly and laterally. Note, there was a large defect in the bladder needing an anastomosis to a small defect in the urethra. There remains a defect in the posterior bladder.

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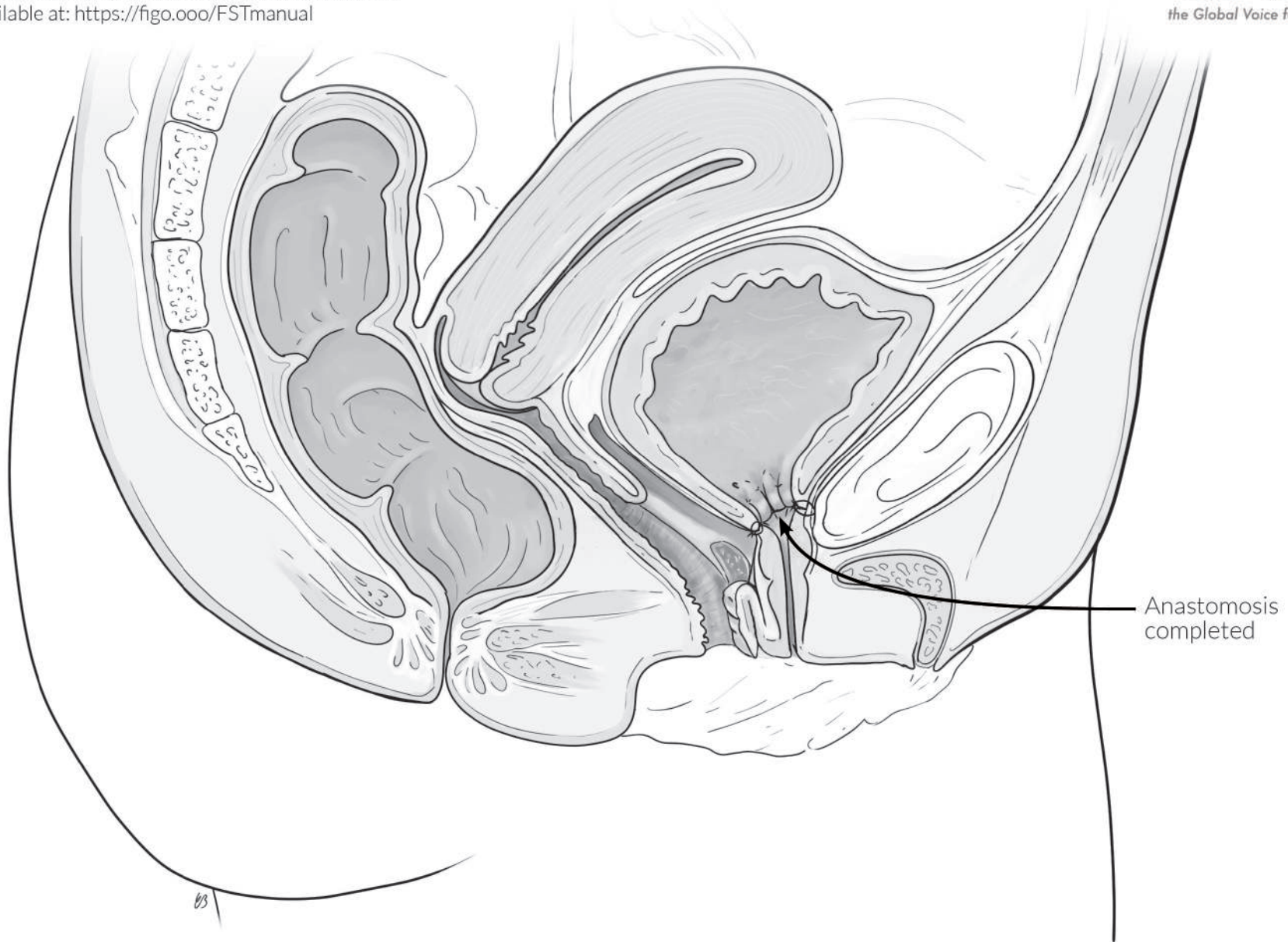


Figure 21. The remaining defect is repaired directly to the urethra.

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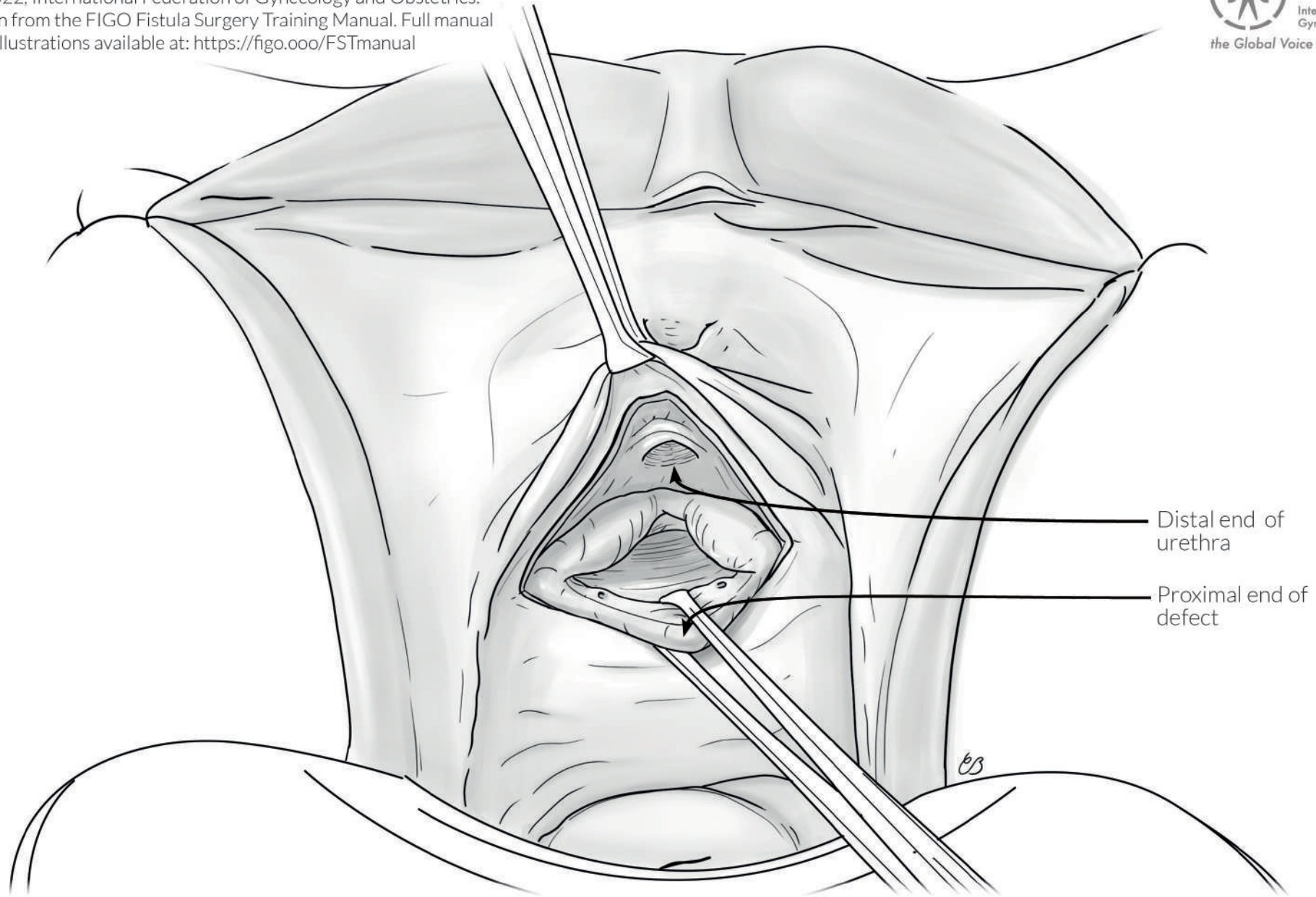


Figure 22. A circumferential defect as seen from the vagina with some vaginal dissection. The ureteric orifices are visible.

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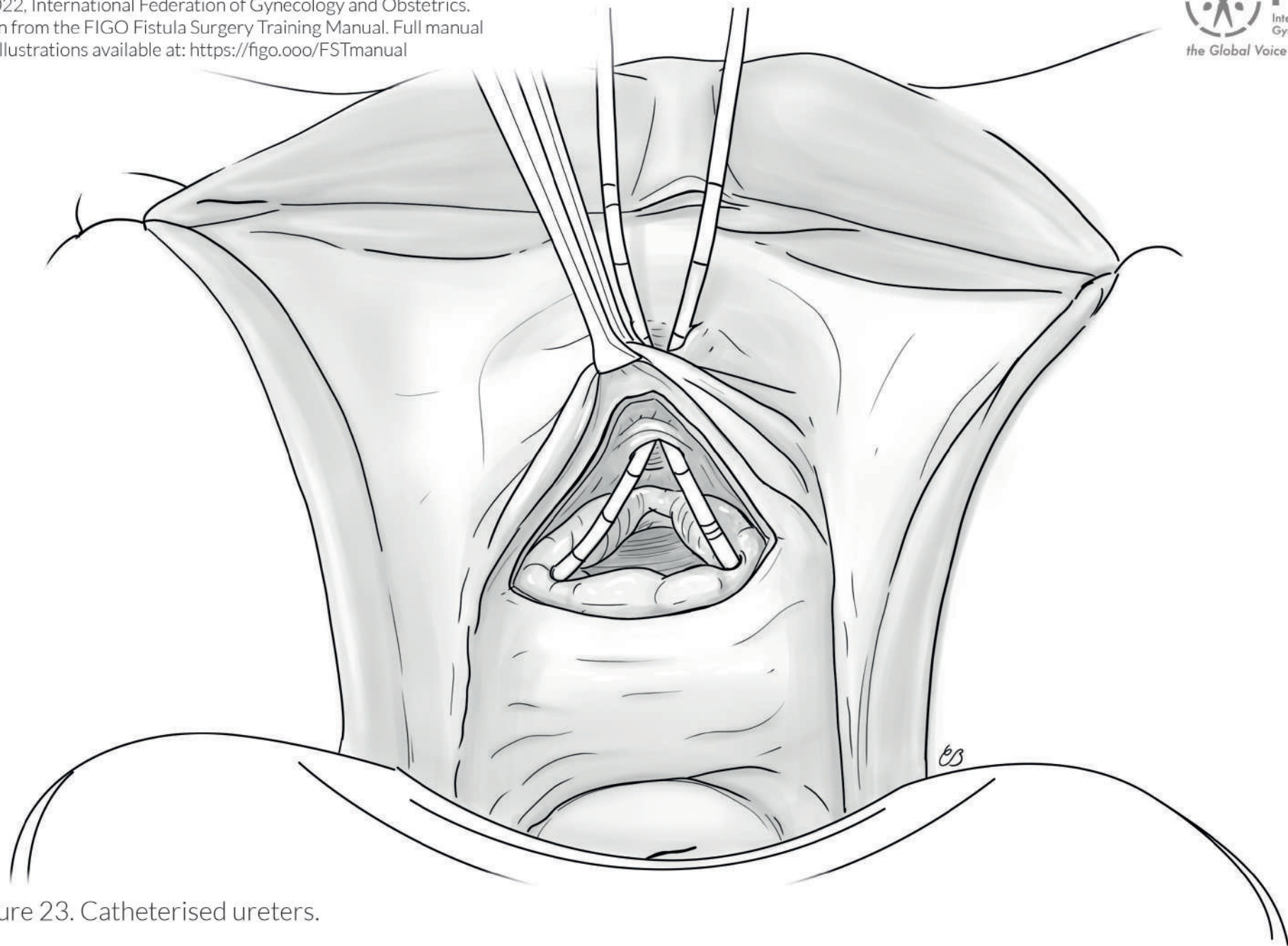


Figure 23. Catheterised ureters.

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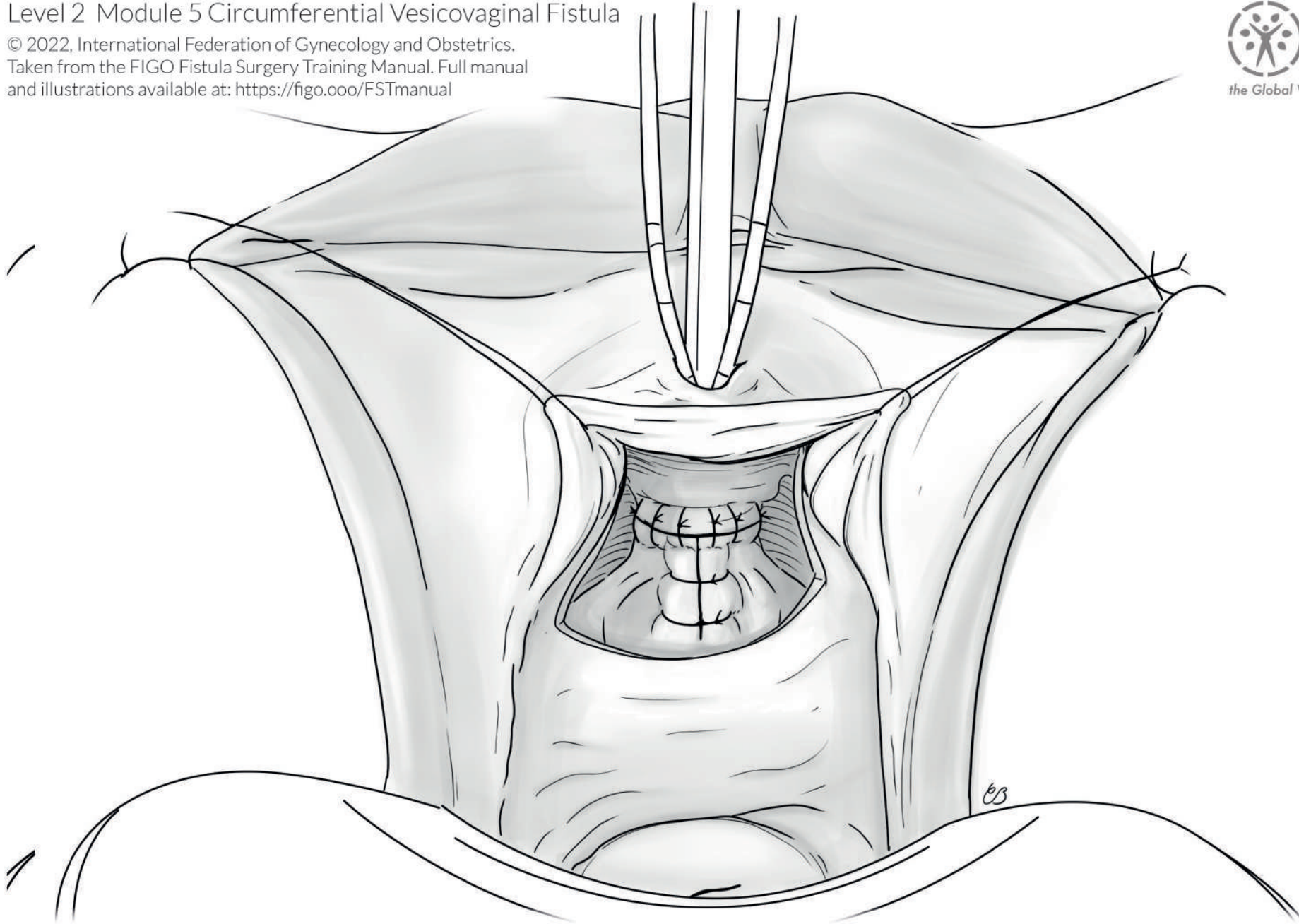


Figure 24. Ureters catheterised and the larger defect in the bladder is anastomosed to the small urethral lumen leaving a defect in the posterior bladder which, in this case, is repaired longitudinally.

Level 2 Module 6 High and Scarred Rectovaginal Fistula

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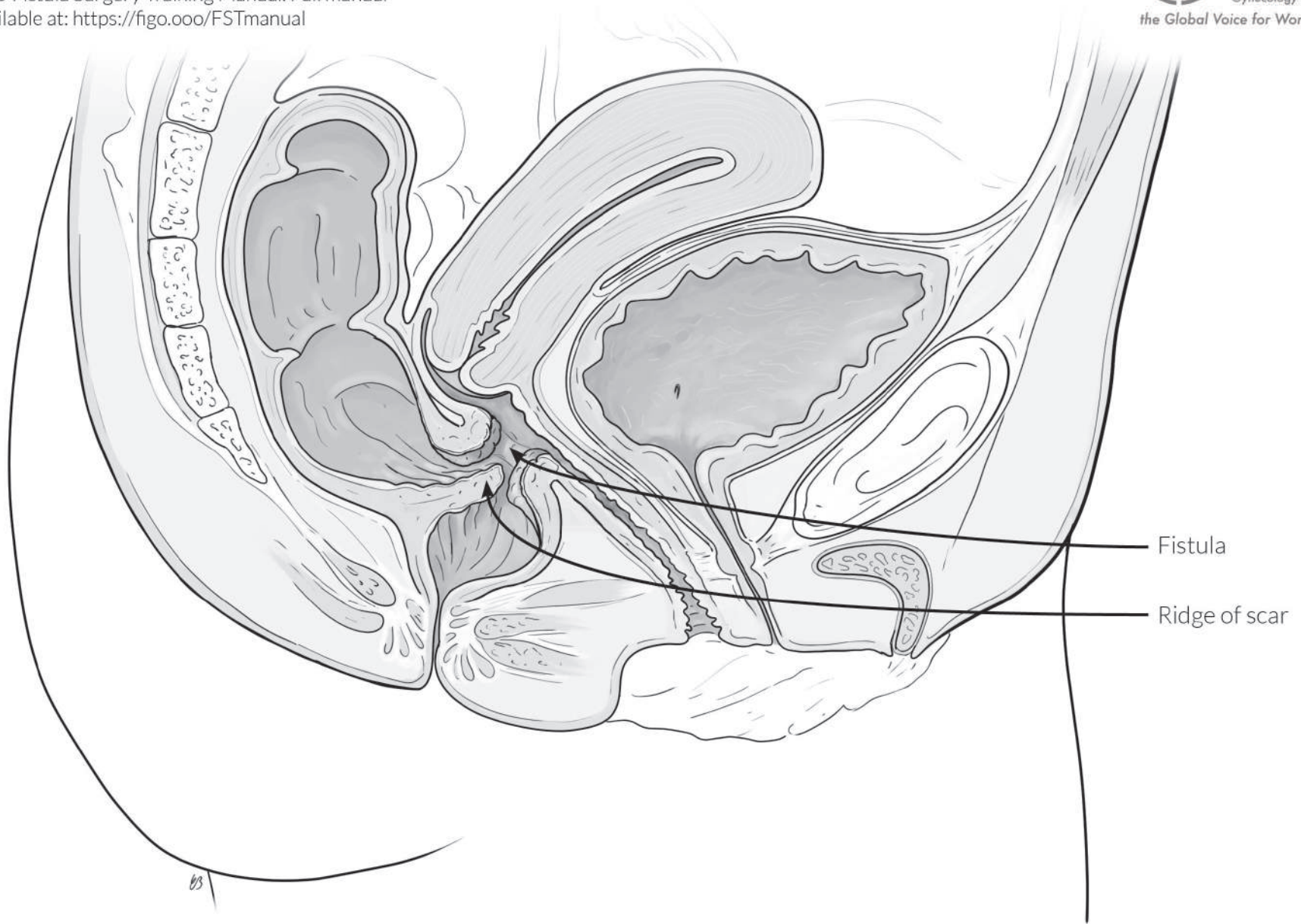


Figure 25. Cross-section of a high and scarred rectovaginal fistula.

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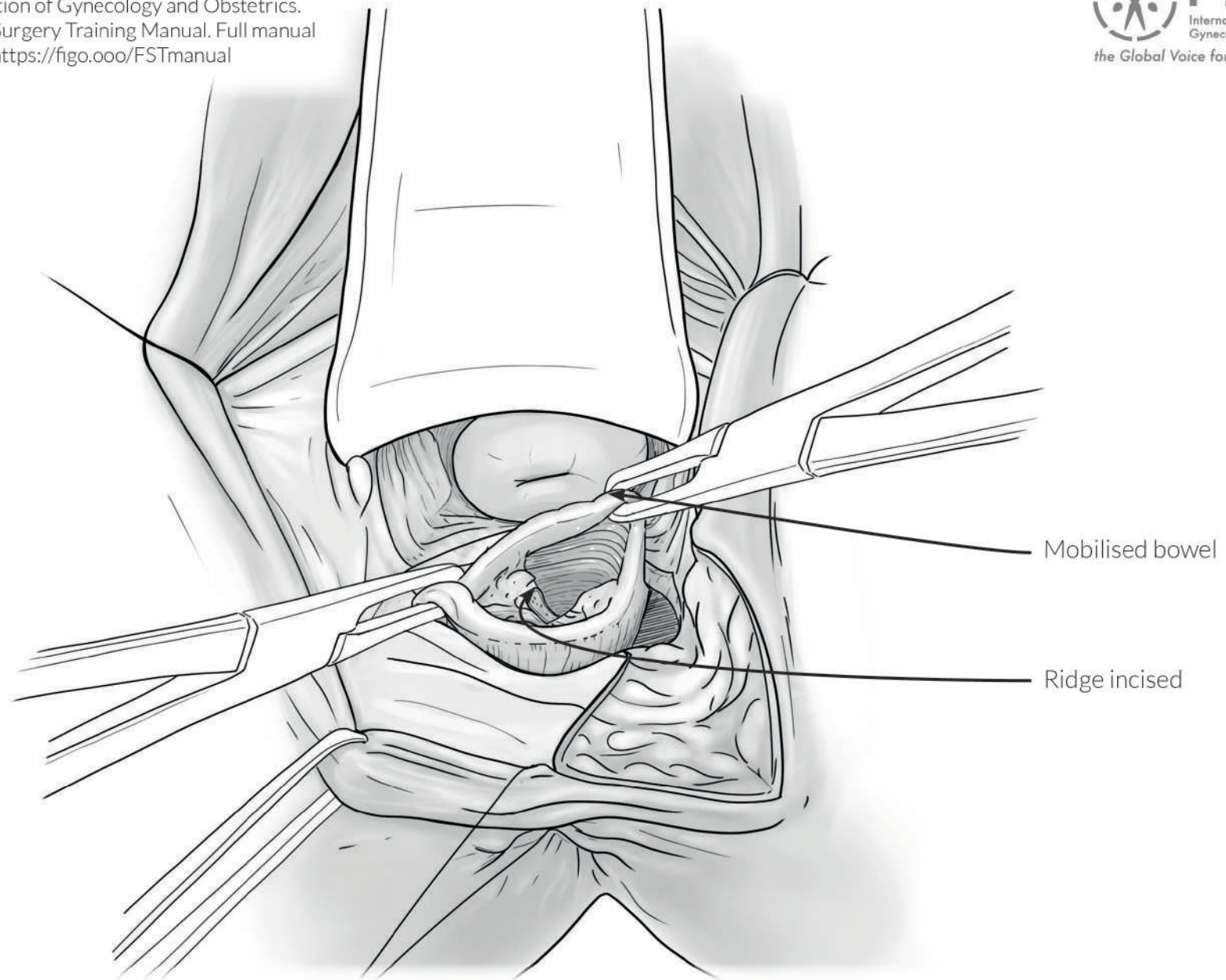


Figure 26. An episiotomy has been performed for ease of access. The vagina is reflected off the rectum and the posterior ridge of scar has been incised.

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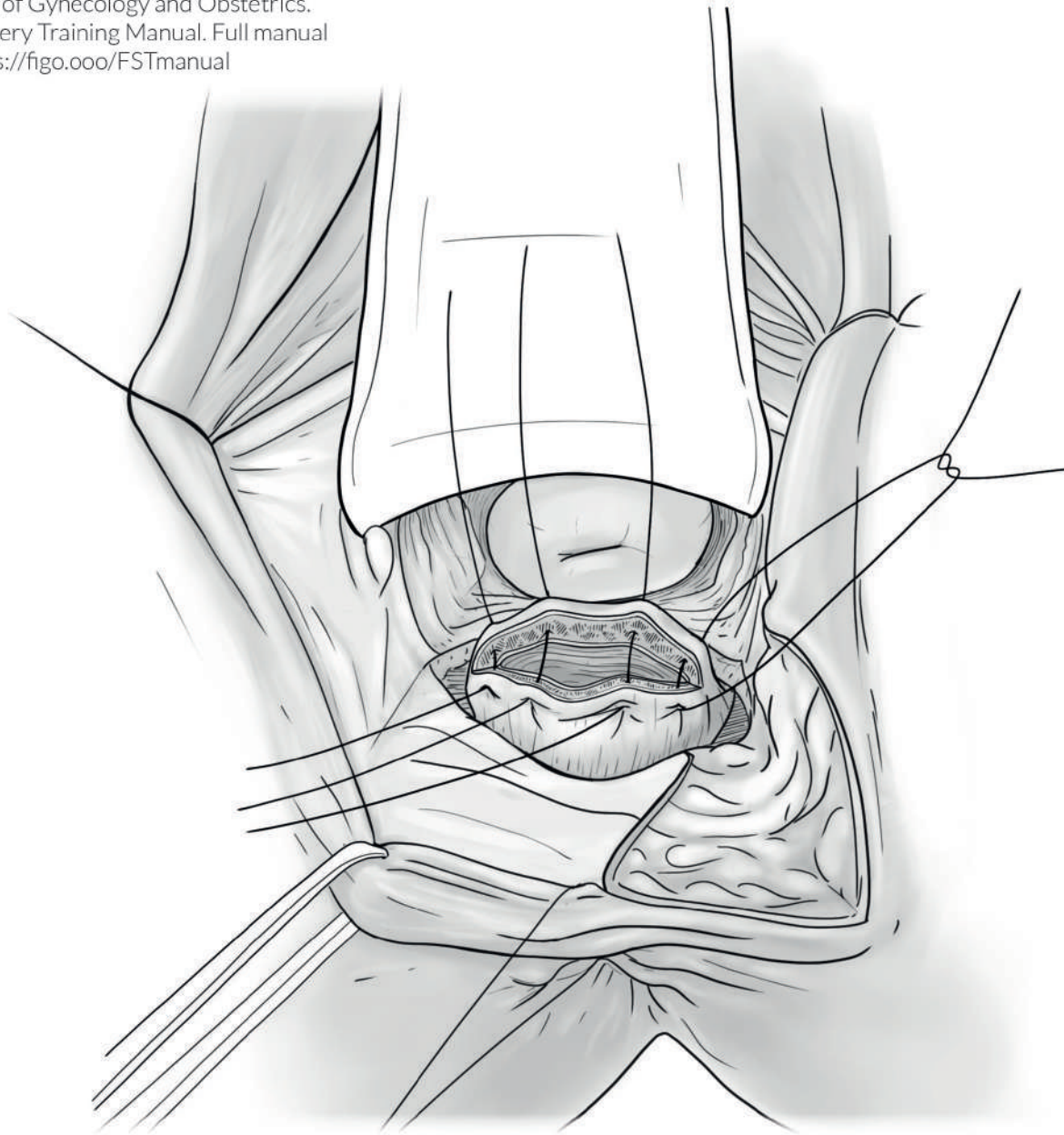


Figure 27. The anterior rectum is repaired with interrupted sutures. The sutures pass through the muscularis layer, excluding the mucosa.

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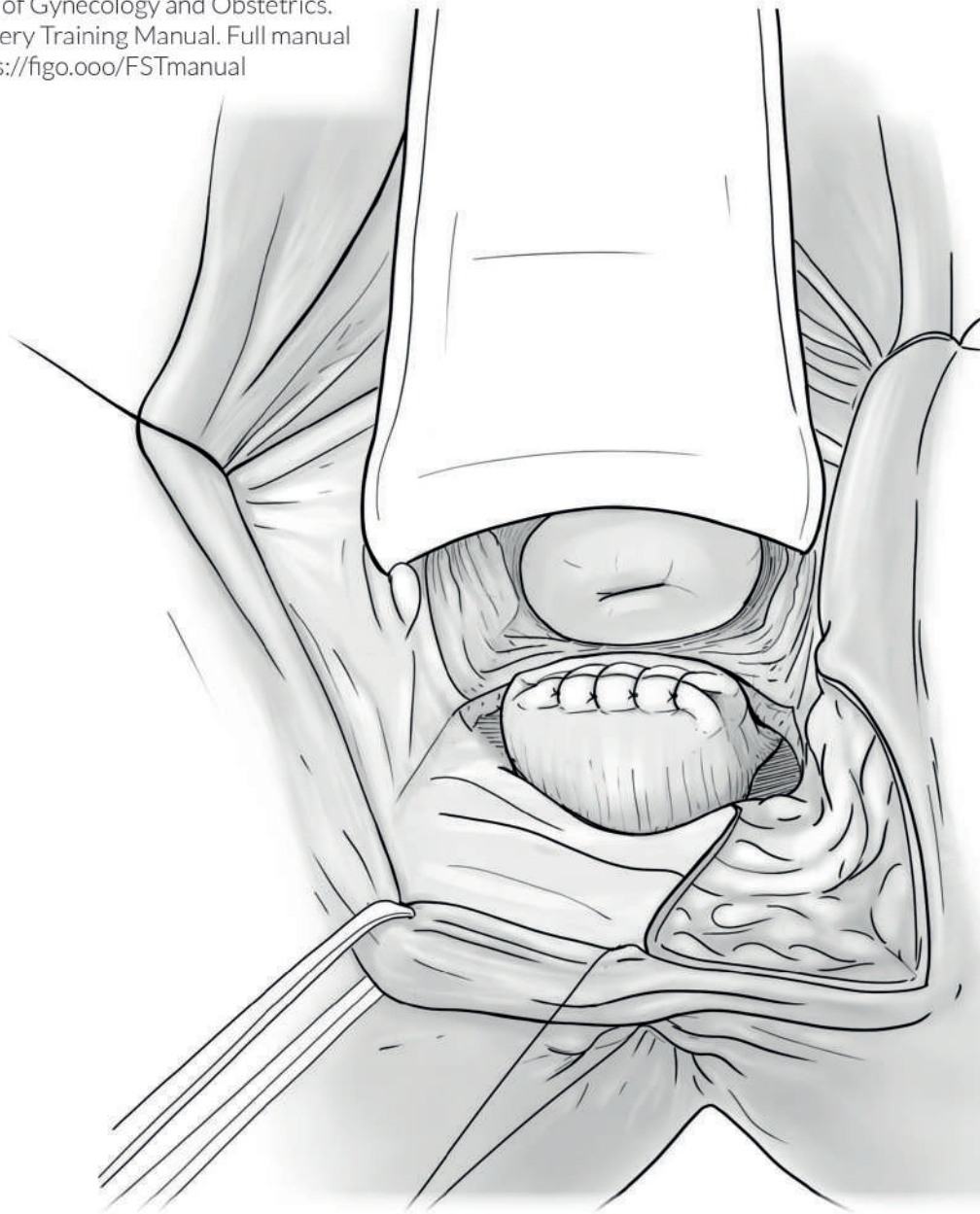


Figure 28. The rectum is repaired in two layers. Make sure the stricture is not occluding the lumen by doing a thorough rectal examination.

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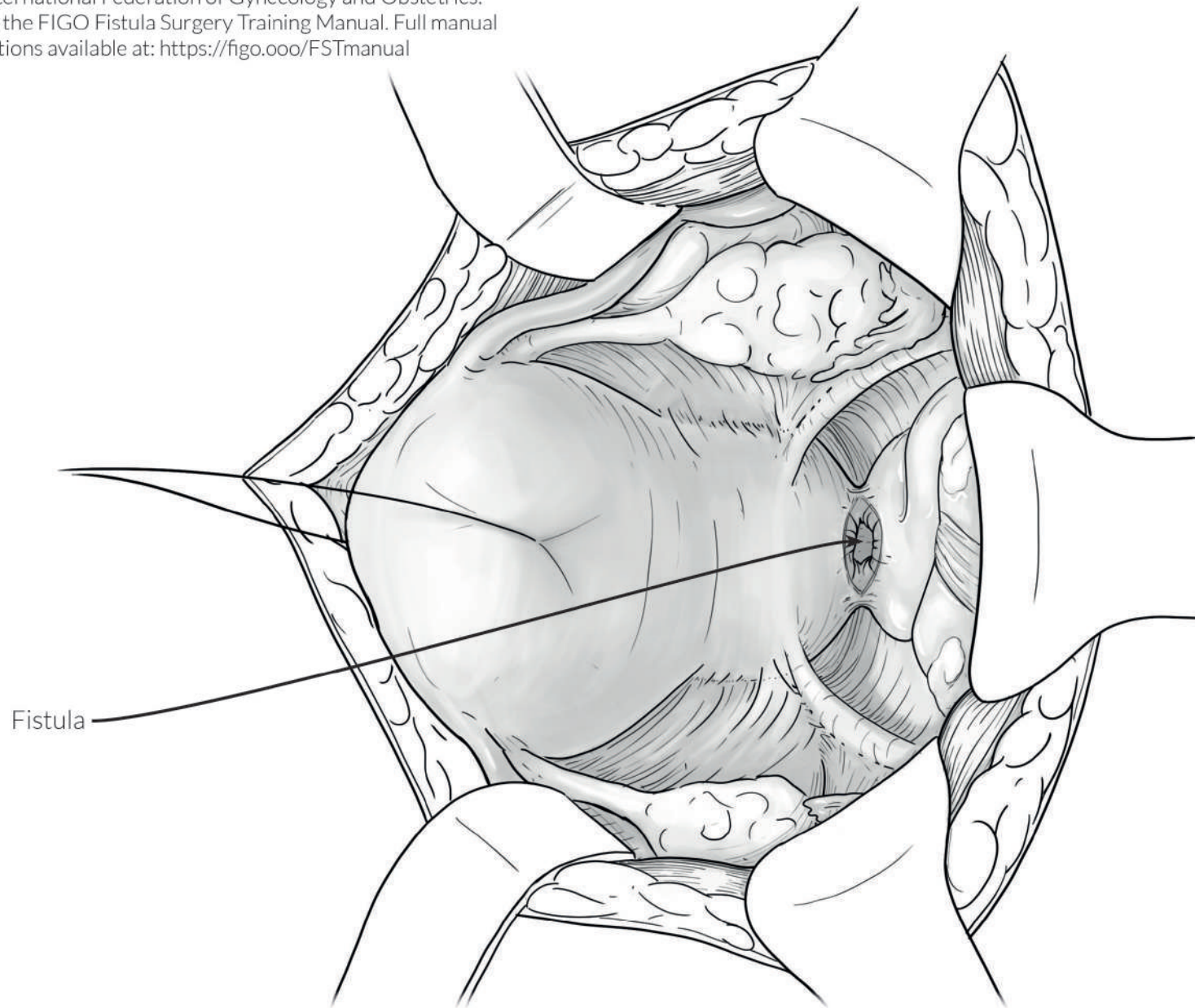


Figure 29. A high rectovaginal fistula as seen at laparotomy. The uterus is retracted with a suture to help expose the fistula.

Level 2 Module 7 Vesicocervical/Vesicouterine Fistula

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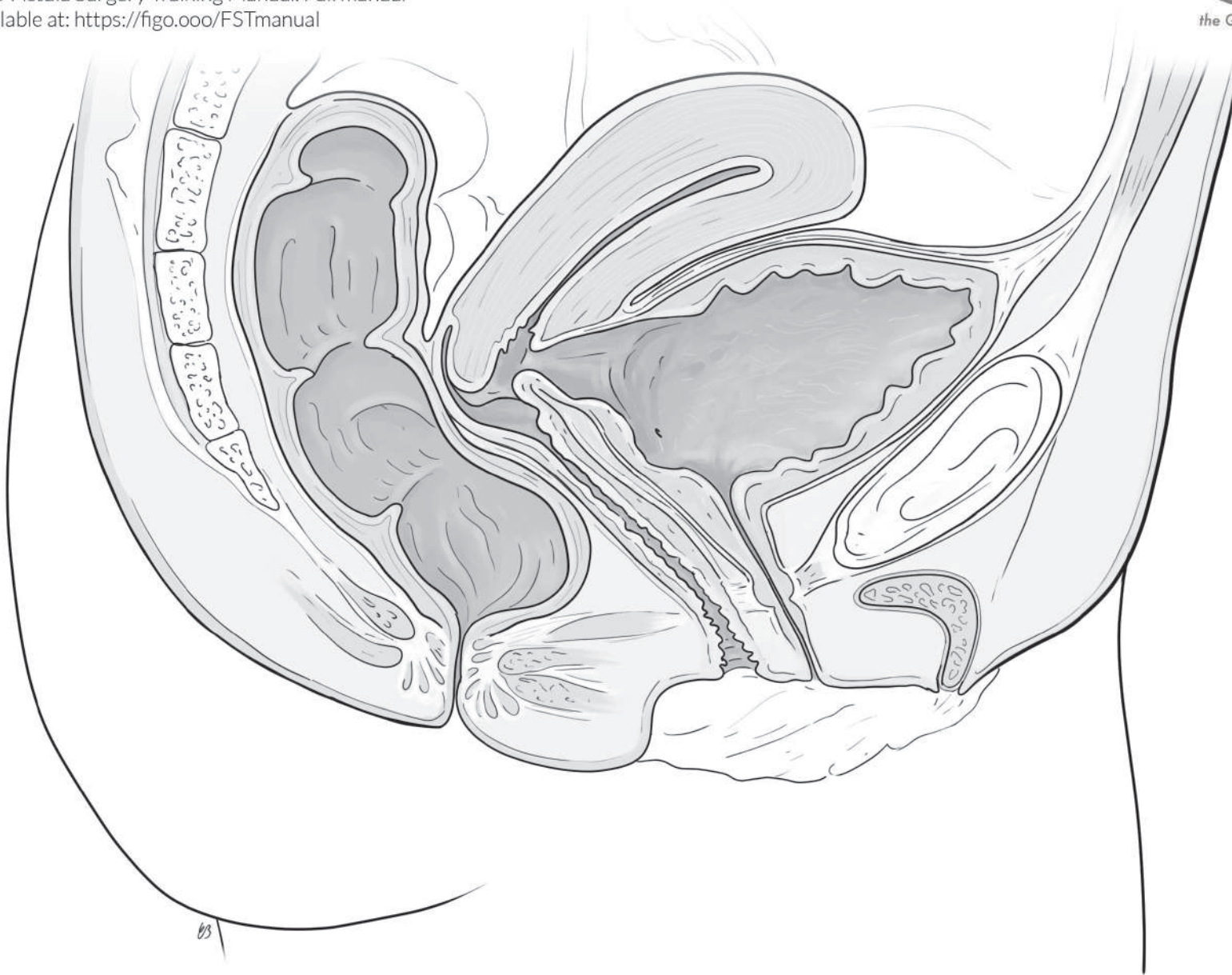


Figure 30. Cross-section of a vesicocervical/vesicouterine fistula.

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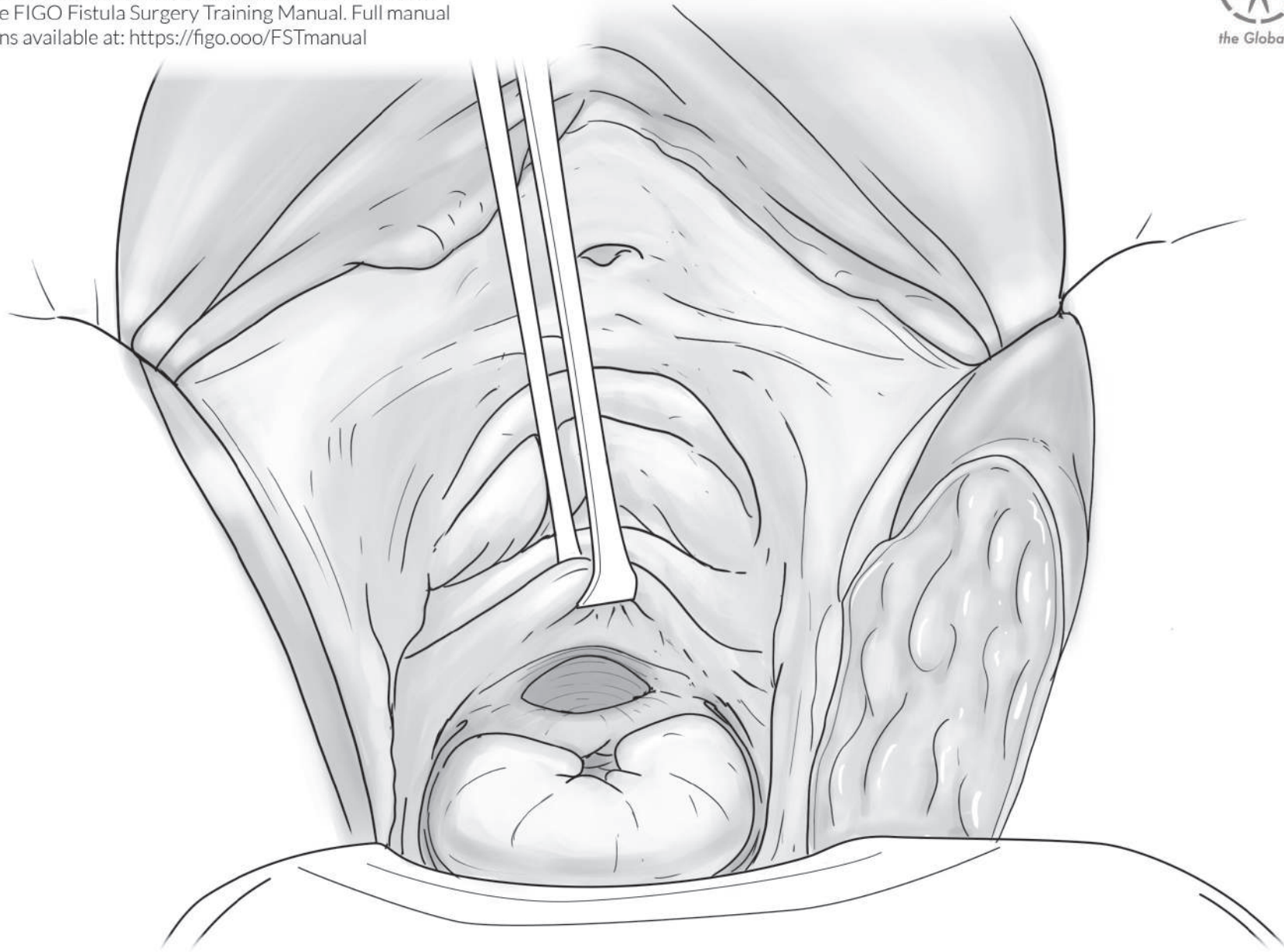


Figure 31. The intracervical fistula as seen from the vagina. Note the anterior cervix is almost missing and the cervical tissue around the fistula is almost absent.

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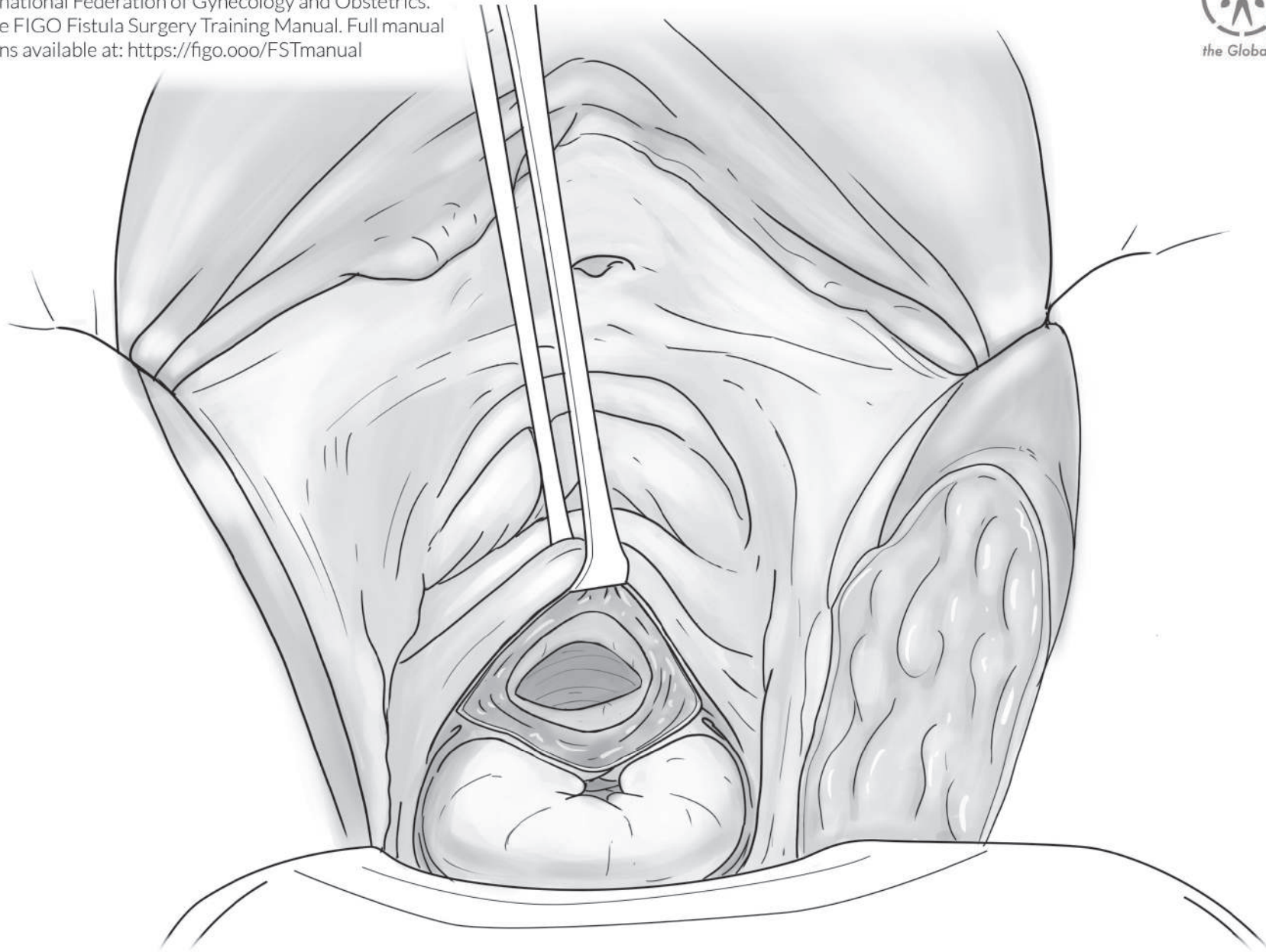


Figure 32. The fistula is mobilised off from the remaining cervix proximally and the vagina distally.

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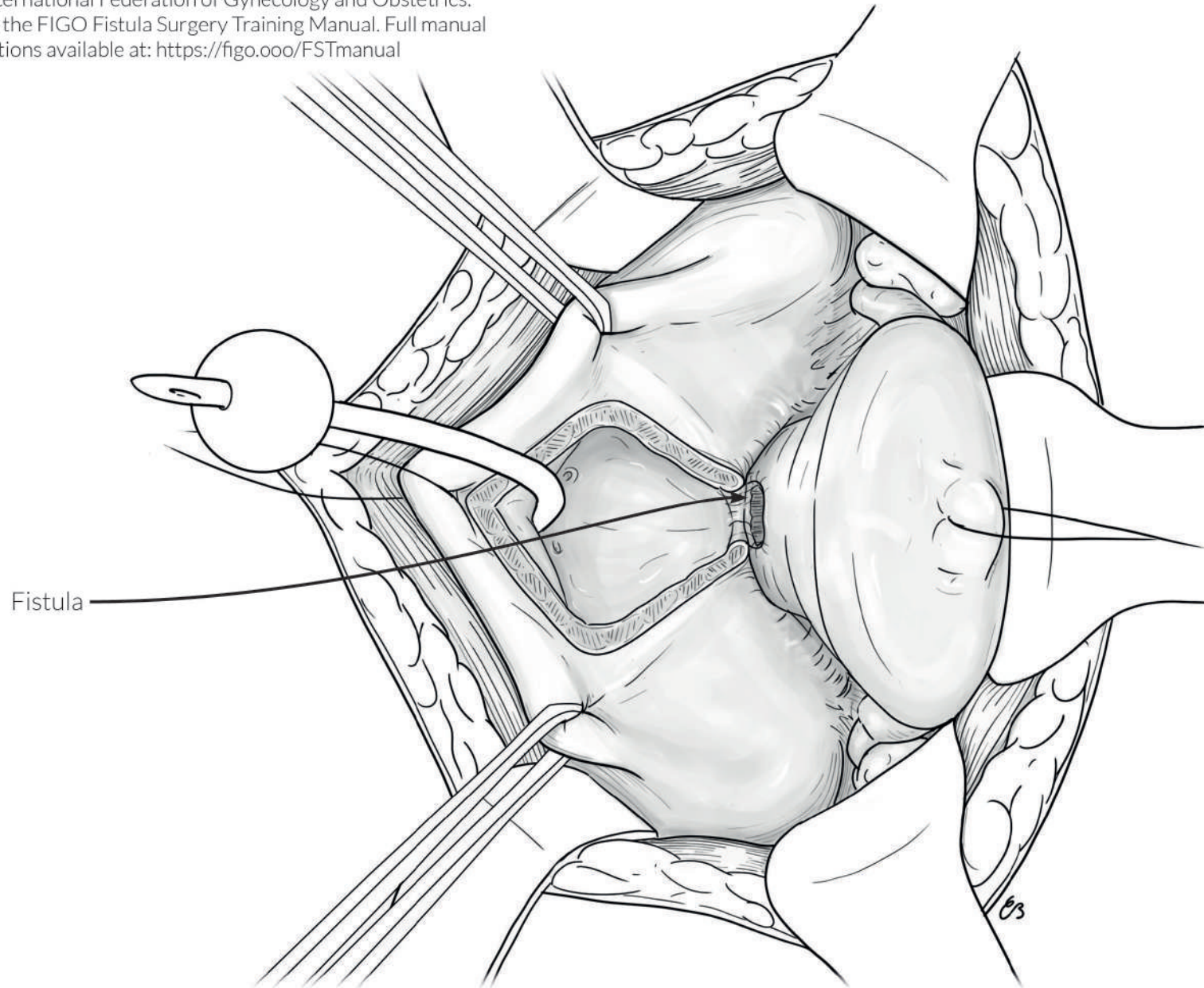


Figure 33. A vesicocervical fistula as seen at laparotomy. A cystostomy has been created and extended to the fistula. The Foley catheter has been brought out through the cystostomy.

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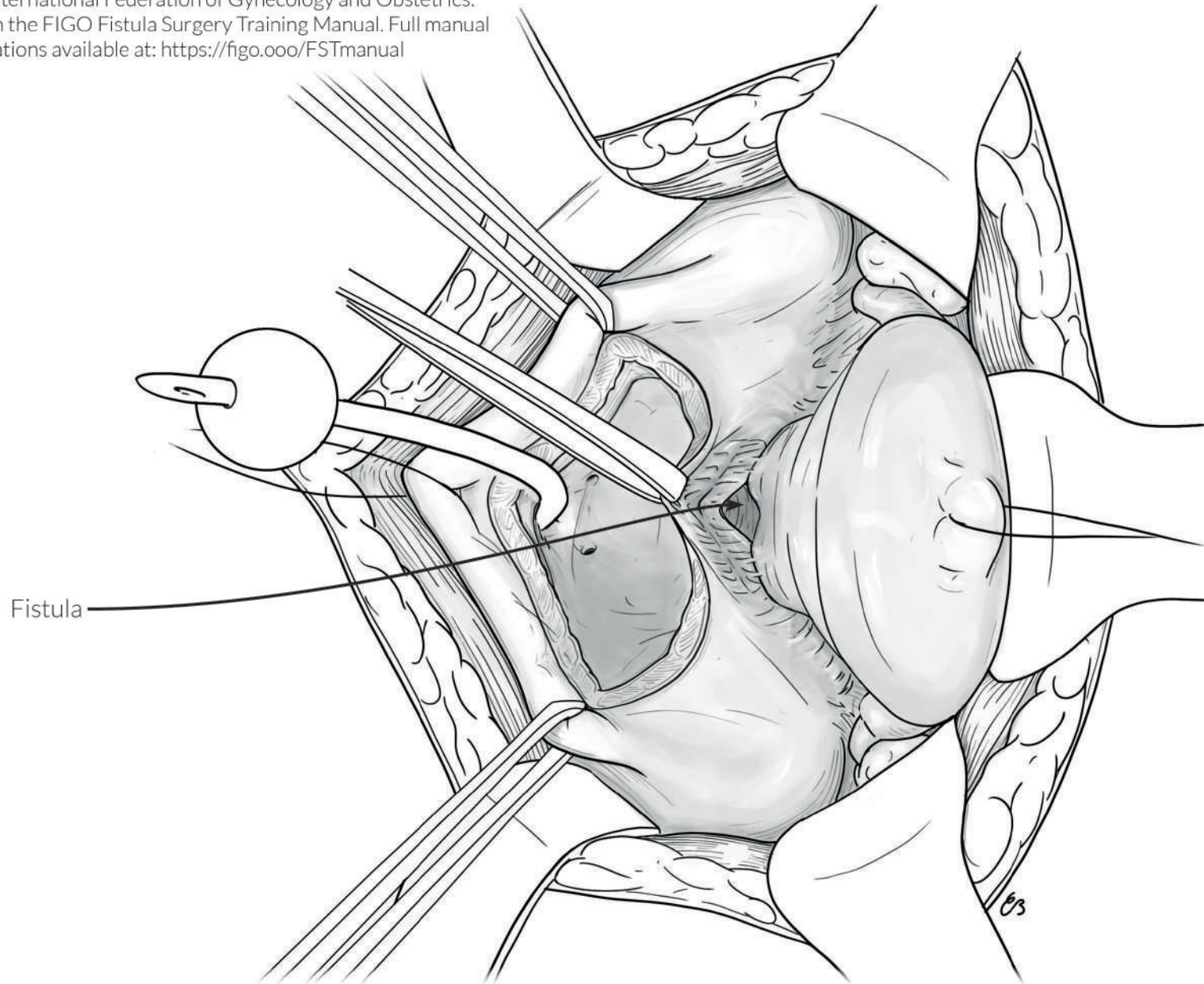


Figure 34. The bladder is mobilised off the cervix.

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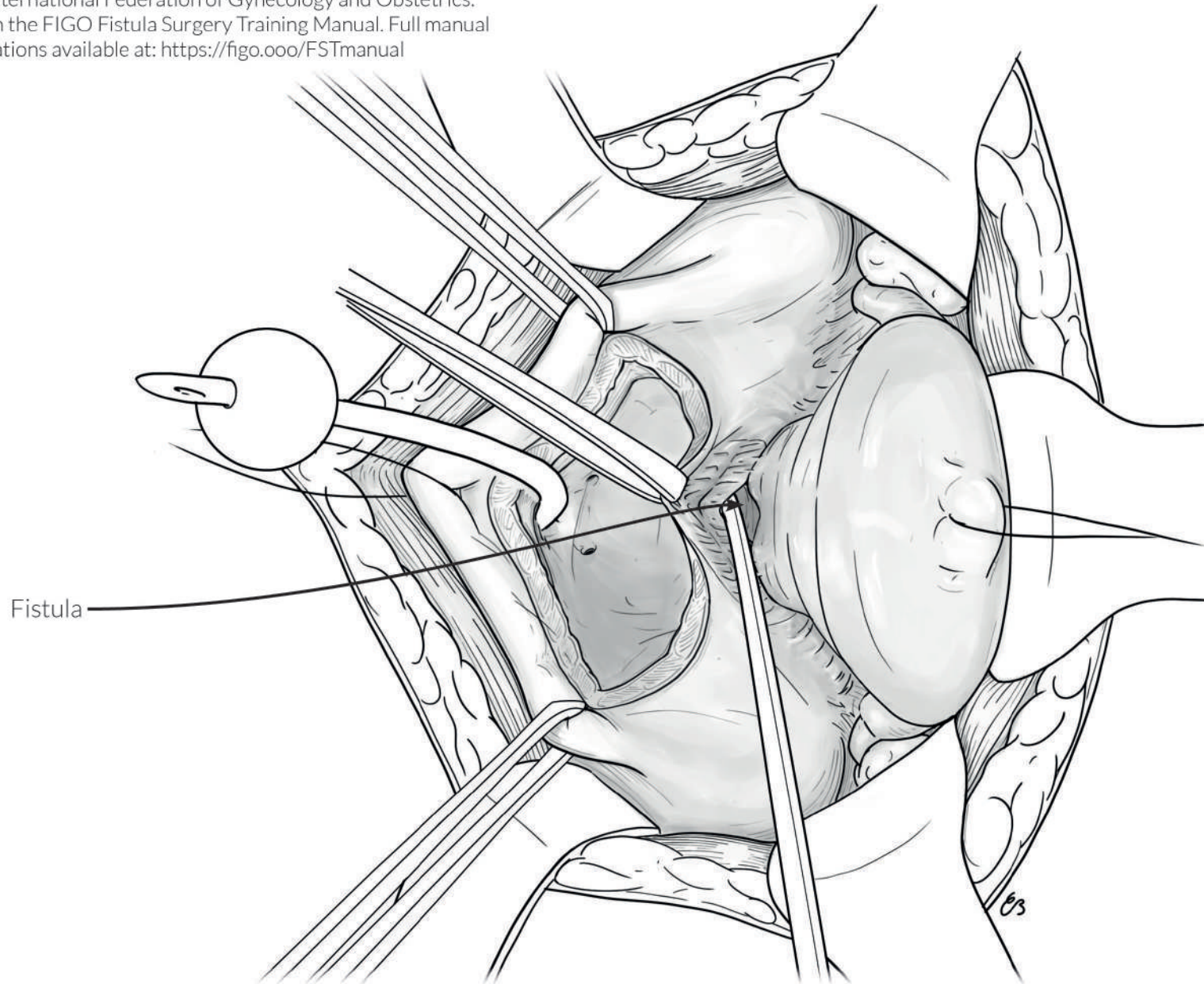


Figure 35. A probe is introduced through the defect in the cervix.

Level 2 Module 8 Residual and Corner Fistula

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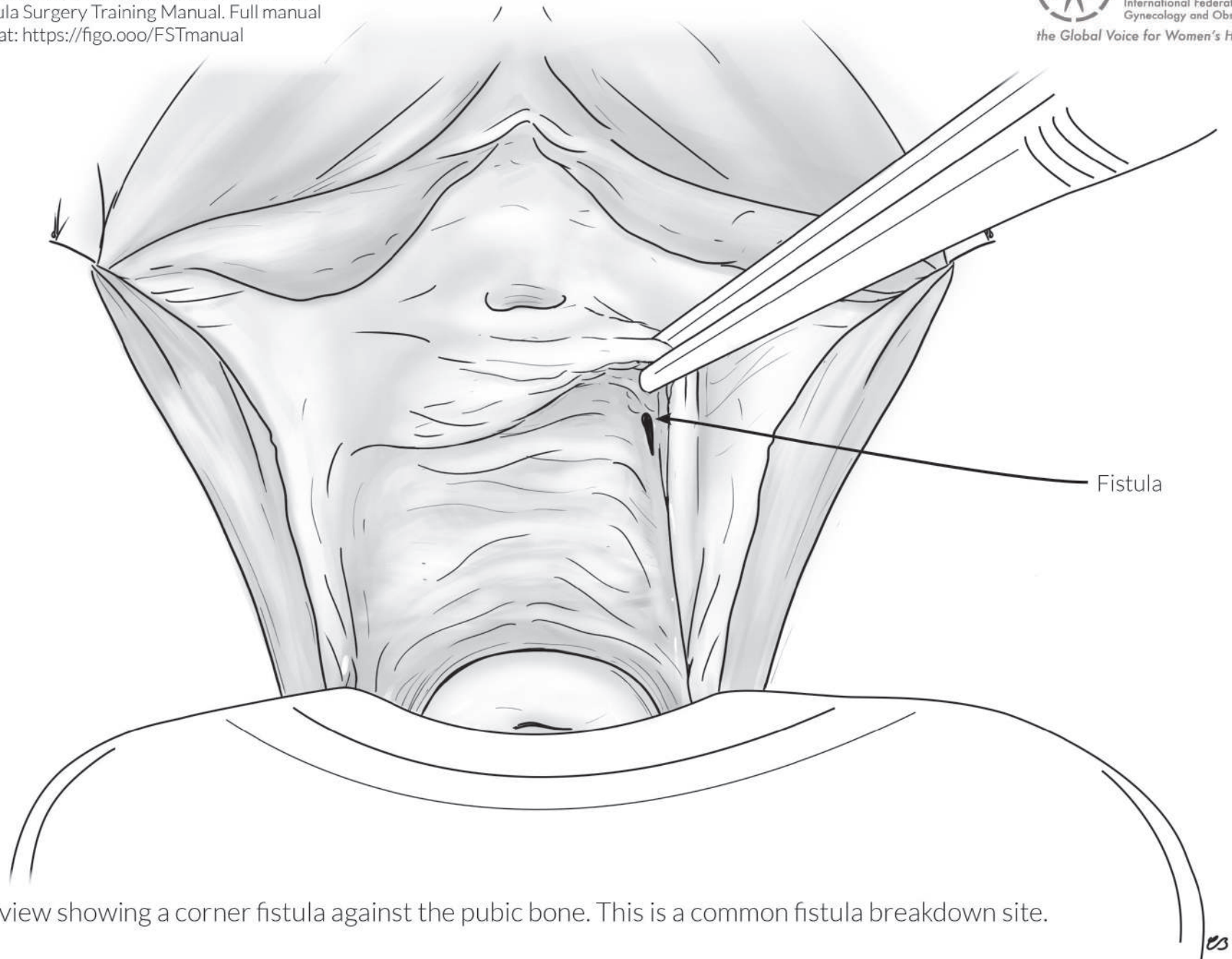


Figure 36. Frontal view showing a corner fistula against the pubic bone. This is a common fistula breakdown site.

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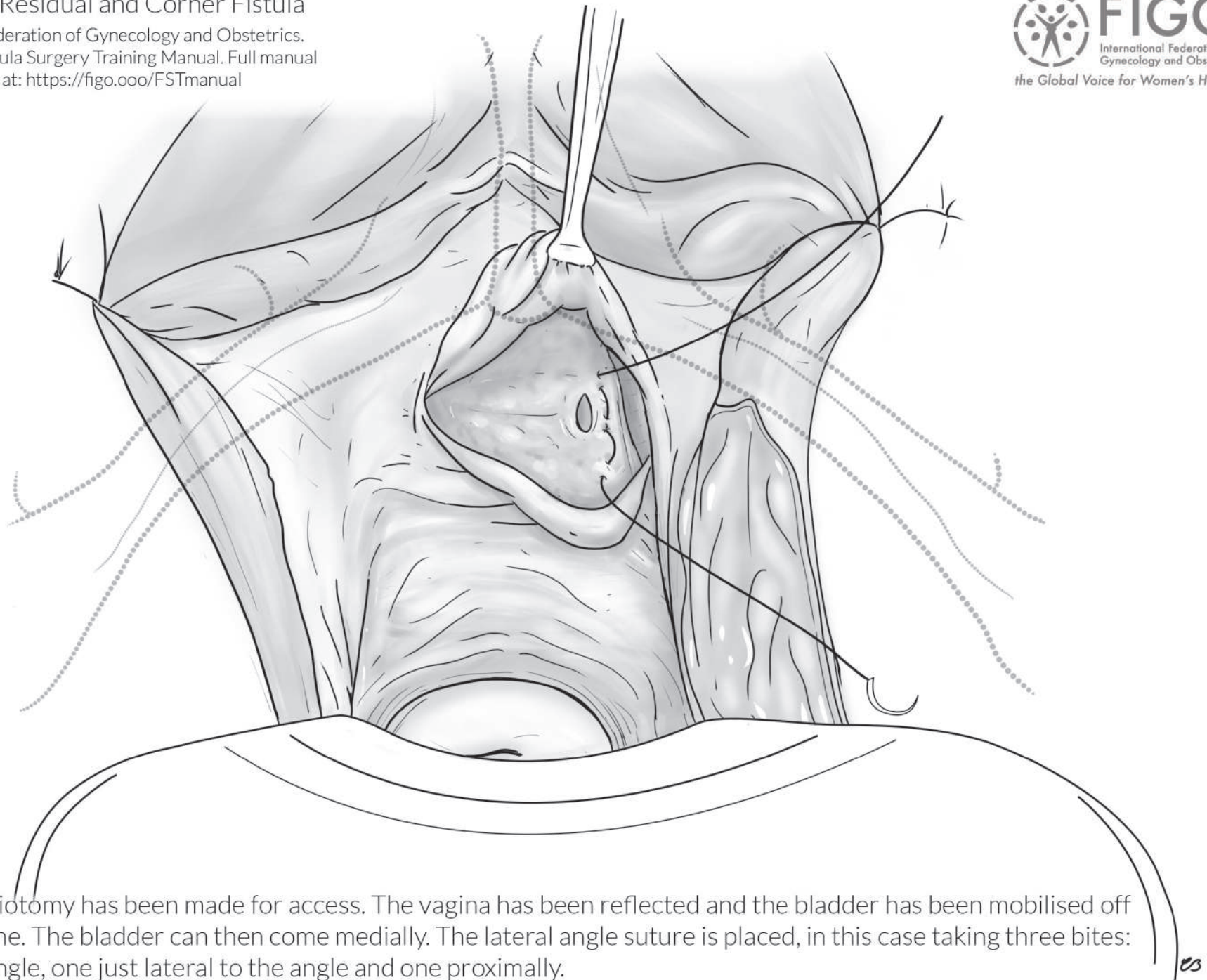


Figure 37. An episiotomy has been made for access. The vagina has been reflected and the bladder has been mobilised off from the pubic bone. The bladder can then come medially. The lateral angle suture is placed, in this case taking three bites: one distal to the angle, one just lateral to the angle and one proximally.

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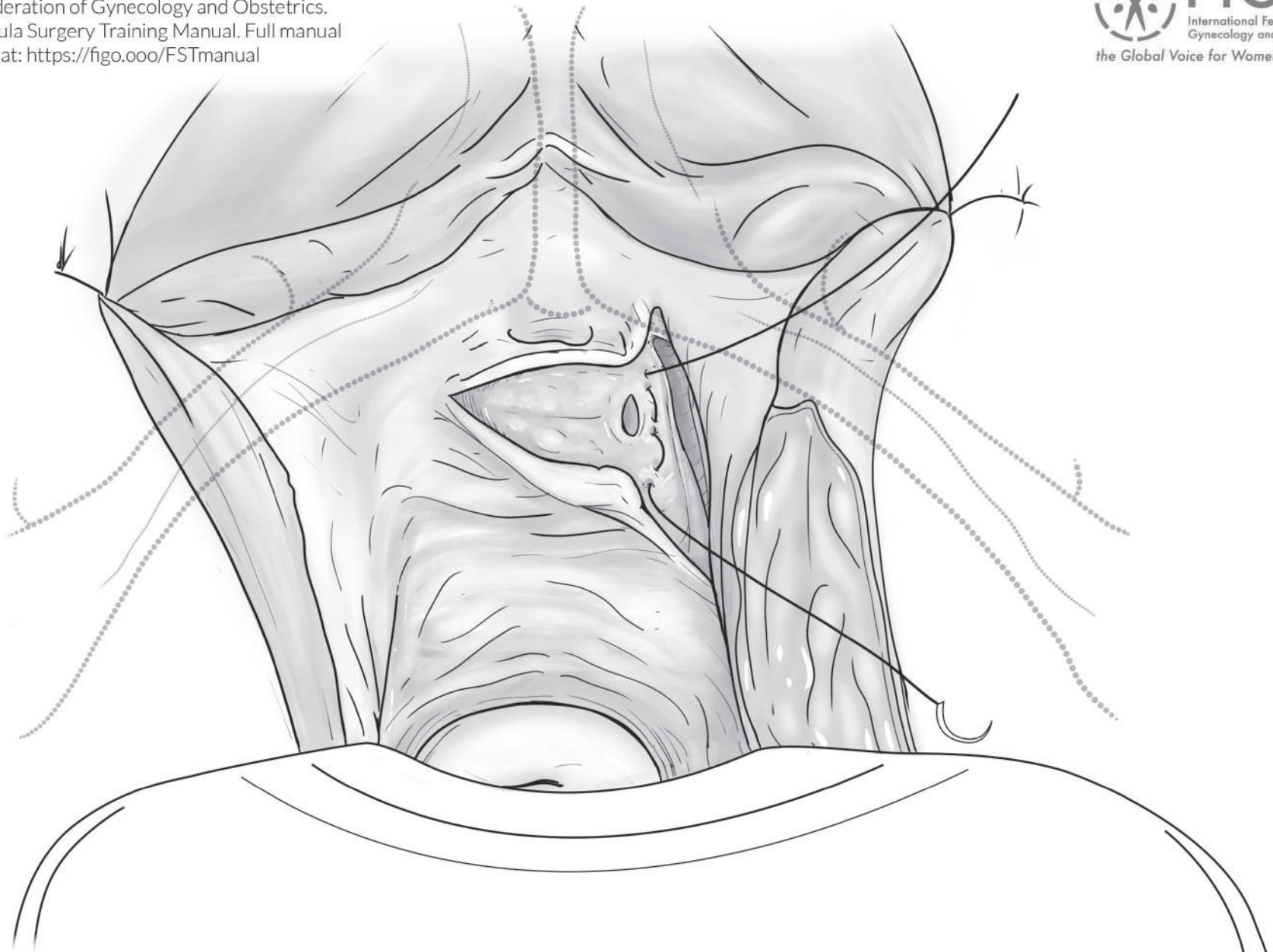


Figure 38. As in Figure 37 but here the vagina has been further reflected off the lateral walls along the sulcus against the bones. This is done proximally and distally to the fistula to help with access.

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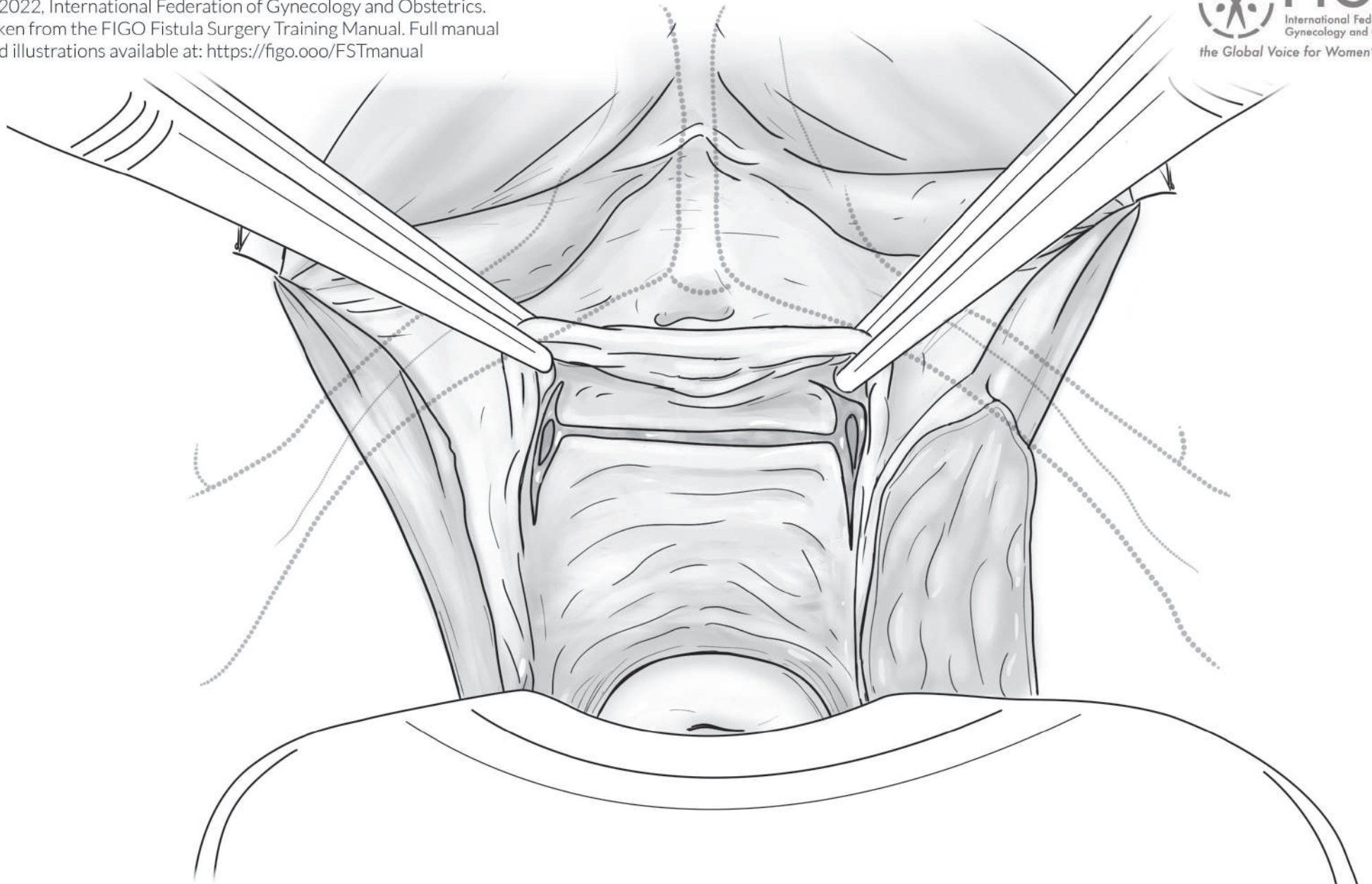


Figure 39. It is common to find bilateral corner fistulas, especially after a circumferential repair that did not secure the anterior urethra/bladder anastomosis satisfactorily. Connect the two fistulas through the vagina to mobilise both.

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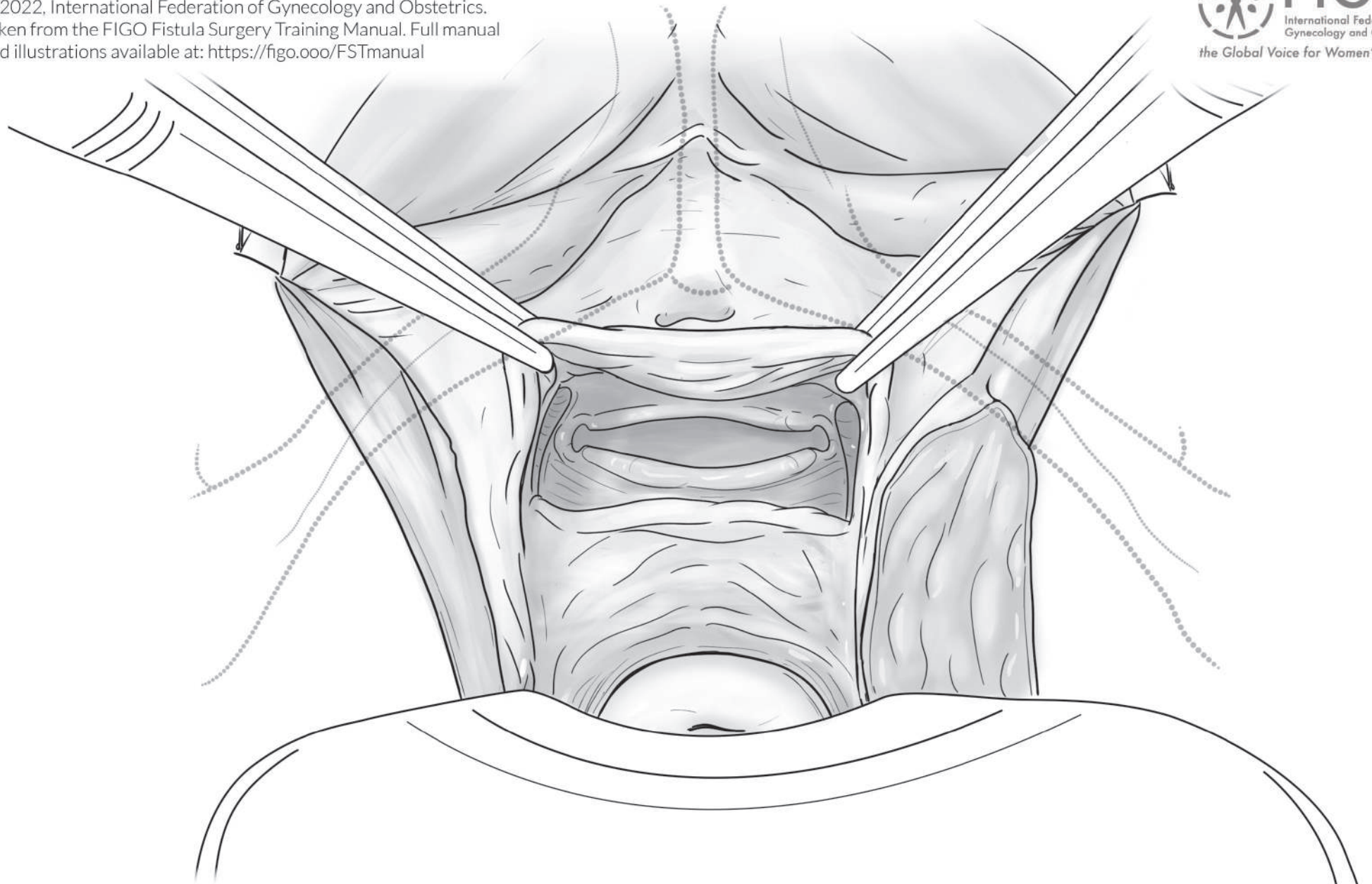


Figure 40. The vagina has been reflected and the two corner fistulas connected to make one large fistula. Often an anterior defect of an old circumferential fistula is revealed here and needs repairing. Note the lateral dissections of the bladder off the pubic bones.