FIGO Fistula Workshop
Addis Ababa, Ethiopia

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Mind the Continence Gap……

Prevention and Treatment

- Prevention: A problem of bladder capacity/function or urethral function
  - Decrease scarring or tethering that causes posterior urethral opening
  - Support for a usually very short urethra
  - Usually impractical to augment the bladder
- Treatment: We employ a patient specific approach
  - Sling: Usually a full length or fascial patch sling
  - Plication: Limited efficacy
  - Alleviation of posterior tethering and sling-like placement of additional skin with Singapore flap
  - Other procedures that seem to make anatomic sense

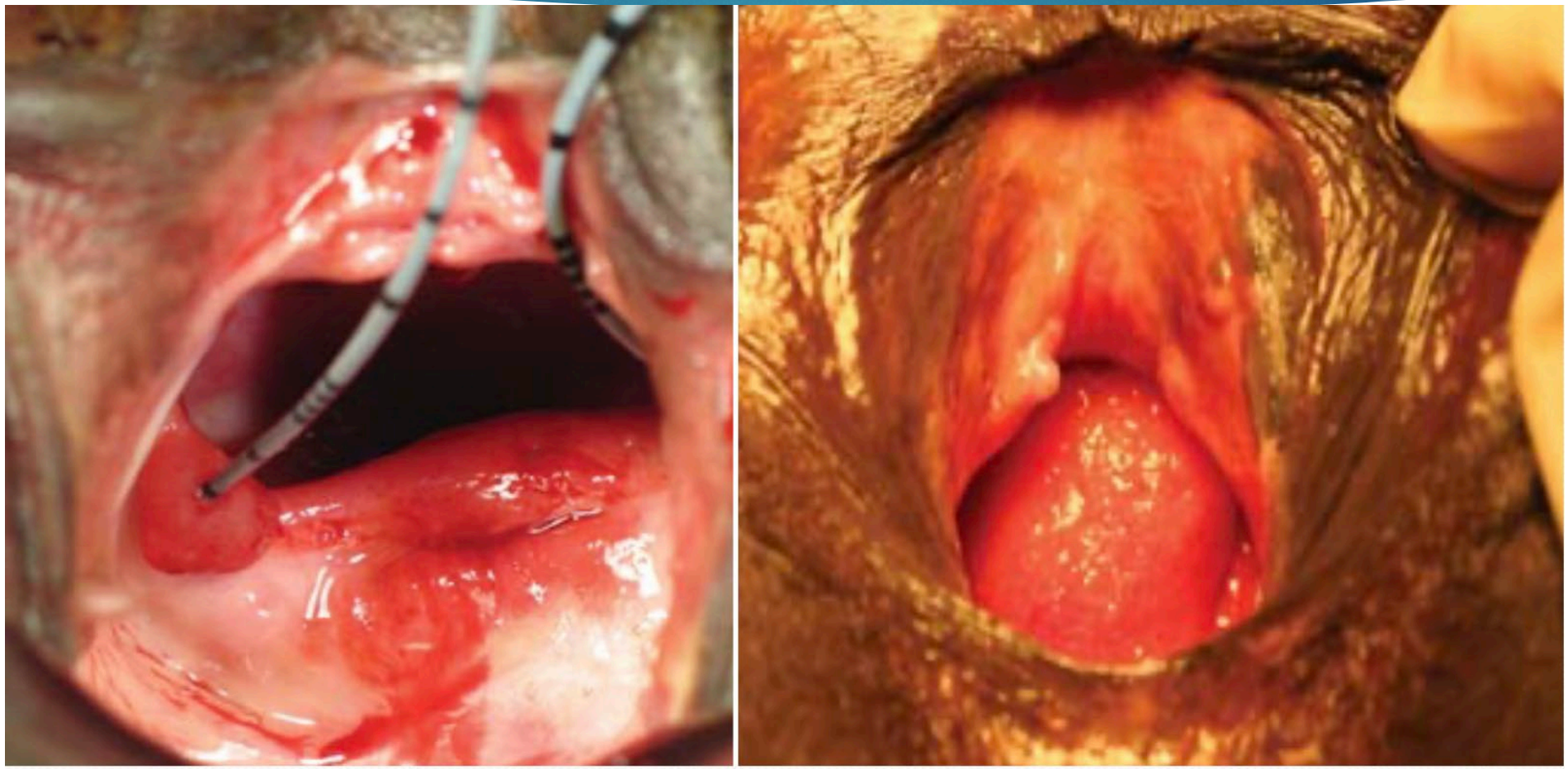
Prevention

- RCT on Fascial vs PC sling
- 1 repair breakdown in the PC group and 3 in the rectus group.
- No significant difference in pad weights or quality of life scores between groups.
- Quality of life scores improved significantly for both groups after surgery.
- Trial terminated because of high breakdown rate in sling group and poor follow-up at one of two sites

Ethics of Randomization in Obstetric Fistula Surgical Care

- Obstetric fistula has one of the most heterogeneous presentations of all surgical conditions
- No two cases exactly the same
- There were likely patients that we might have excluded from the fascial sling group because of the appearance of a "thin" urethra or that we would have favored a fascial sling because of better tissue etc
- We rarely now place a fascial sling at the time of high stage circumferential fistula repair.
- Should it be considered

Rectus Muscle Interpositional Rotational Flap



Hancock

Rectus Muscle Interpositional Rotational Flap

- Experience limited to cases and case series
- For complex, post-radiation etc, fistulas
- Abdominoperineal reconstruction
- For Complex Stress Urinary Incontinence (Wall, 1996)
- Extensive use of TRAM flap for breast reconstruction demonstrates that patients can do well without rectus
- Provides a moderate to large bulk (Sometimes a problem), highly vascularized, reliable flap
- Bulk limits practical use in repeat cases where retropubic space is difficult to access
- Moderate difficulty. Challenging or impossible if prior disruption of the inferior epigastric vessels or in repeat repairs

Rectus Muscle Interpositional Rotational Flap

- Can be performed with or without skin or posterior sheath/peritoneum
- Skin use complicates breast reconstruction
- Theoretically more shearing stress of skin with vaginal placement
- Use of posterior sheath/peritoneum to replace vagina is compelling
  - Technically more challenging than rectus muscle alone
  - Concerns over ? higher risk of hernia
  - Intraperitoneal entry necessary

Rectus Muscle Interpositional Rotational Flap

- Cases series from 4 months ago
- 4 mentored cases with sheath with plastic surgeon, 1 with neourethra
- 2 subsequent cases without sheath
- 3 month follow-up completed
- 4 patients dry or mostly dry, 3 performing intermittent self cath with slowly decreasing PVR's
- 1 patient of these cannot void much at all
- 1 patient leaks with urgency

- All sheath patients had no anterior vagina to repair
- The patient with the neourethra has very short, scarred vagina despite 5 cm depth at end of case, but is completely dry
- One patient required take back to OT at 7 days for anterior to posterior agglutination
- Most vaginas are still short 5-7 cm with apical scarring