



VAGINAL REPAIR of a FISTULA between the BLADDER & VAGINA

Information about your procedure from
The British Association of Urological Surgeons (BAUS)

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.

To view this leaflet online, scan the QR code (right) or type the short URL below it into your web browser.



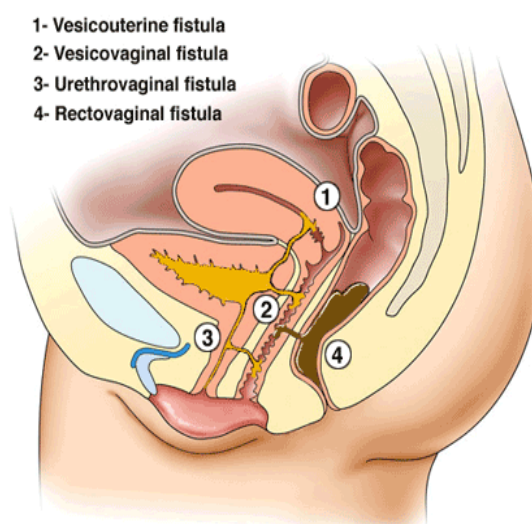
<http://rb.gy/blgar>

KEY POINTS

- This is a procedure to repair a vesicovaginal fistula (an abnormal connection between your bladder and vagina)
- It is performed using an incision (cut) inside your vagina
- You will have a bladder catheter (a tube that stays in the bladder to allow urine to drain out) for several weeks
- Sometimes, a fistula repair does not work or the fistula comes back later

What does this procedure involve?

A vesicovaginal fistula is an abnormal connection between your bladder and vagina (No 2 in the image, right). This procedure is to repair the fistula and prevent urine leakage. It is sometimes done through an incision (cut) inside your vagina and sometimes through an incision into your abdomen (tummy) or using keyhole surgery (laparoscopic or robotic).



This leaflet is about the operation through the vagina.

What are the alternatives?

- **No treatment** – sometimes we do not treat a small fistula if the leakage can be managed with a continence pad
- **Urethral catheterisation** – sometimes we put a catheter inside your bladder to keep it empty; this is a small tube made of silicone or latex which passes through your urethra (waterpipe). Occasionally, a fistula can heal by itself if a catheter is left in for several weeks
- **Abdominal fistula repair** – vesico-vaginal fistulae can also be repaired through an incision into your abdomen, or using keyhole surgery (laparoscopic or robotic)
- **Nephrostomy tube insertion** – insertion of drainage tubes into both kidneys to divert urine (in selected patients only)

What happens on the day of the procedure?

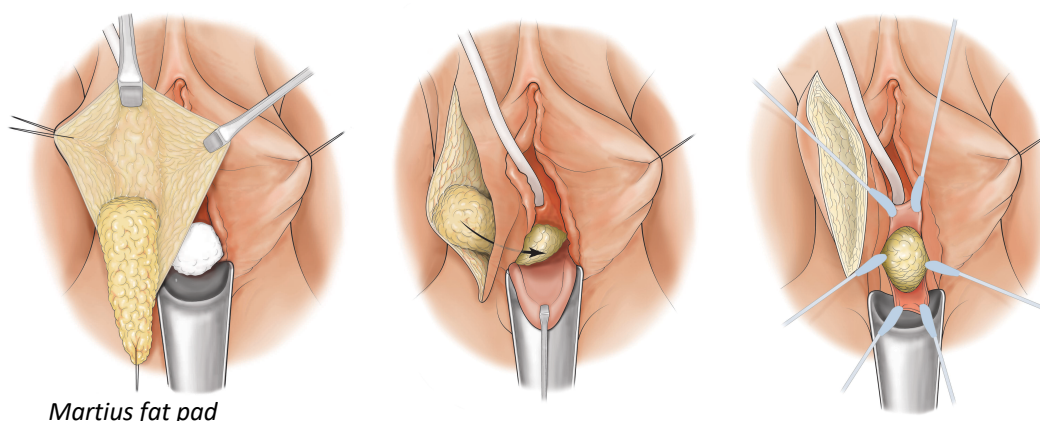
You will be seen by the surgeon and the anaesthetist who will go through the plans for your operation with you.

We may provide you with a pair of TED stockings to wear, and give you an injection to thin your blood. These help to prevent blood clots from developing and passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

Details of the procedure

- we normally do the procedure under a general anaesthetic (i.e. with you asleep)
- we look inside the water pipe and bladder using a telescope (cystoscope)
- we may use the telescope to pass a flexible wire or plastic tube into your ureters (the tubes that connect your kidneys to your bladder), to prevent them from being damaged during the procedure
- we make an incision inside your vagina
- we separate your bladder from your vagina and repair the fistula with dissolvable stitches

- we reinforce the area around the fistula by putting some of your body's own tissue between the bladder and vagina; we usually take a piece of fatty tissue called a **Martius fat pad flap** from your labia (the hair-bearing vaginal lips, pictured below © Tamsin Greenwell)











- if labial tissue is used, we sometimes leave a small drain in place to prevent blood clots from developing; it is usually removed after a day or two
- we use dissolvable stitches in your vaginal skin (and in your labia, if needed) which disappear in the majority of patients after two to three weeks
- we often put a small pack inside your vagina; this is usually removed the next day
- we put a catheter into your bladder through your urethra; this allows your bladder to heal and your surgeon will tell you when it will be removed
- we may put a second catheter through your abdominal wall into your bladder as well; this is called a suprapubic catheter





You may get some bleeding from your vagina for the first few days, but this usually settles quickly.

Your catheter needs to stay in for at least two weeks, but you will be able to go home with the catheter. You will then come back to hospital to have it removed. It is common to do a dye X-ray before removing the catheter, to check that your bladder has healed fully.

Are there any after-effects?

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. We have not listed very rare after-effects (occurring in less than 1 in 250 patients) individually. The impact of these after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Mild bleeding in your urine for the first 24 to 48 hours	 Almost all patients
Temporary pain in your incisions requiring simple painkillers	 Almost all patients
Failure of the procedure (the fistula does not heal and urine leakage continues)	 Between 1 in 10 & 1 in 20 patients (5 – 10%)
Chronic (long-term) pain in your vagina or pelvis	 Between 1 in 10 & 1 in 20 patients (5 – 10%)
Altered bladder function (frequency & urgency) which may be permanent	 1 in 20 patients (5%)
Wound infection	 Between 1 in 20 & 1 in 50 patients (2 – 5%)
Stress incontinence (leaking when you cough, sneeze, exercise or strain)	 Between 1 in 20 & 1 in 100 patients (1 – 5%)
Vaginal narrowing/stenosis or adhesions	 Between 1 in 20 & 1 in 100 patients (1 – 5%)

Scarring of the ureters (the tubes that connect the kidneys to the bladder) requiring further surgery	 Less than 1 in 50 patients (less than 2%)
Change in the shape or appearance of the labia (vaginal lips)	 Less than 1 in 50 patients (less than 2%)
Severe bleeding requiring a further procedure	 Between 1 in 50 & 1 in 250 patients
Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)	 Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)

What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is between 4 & 6%; this includes getting *MRSA* or a *Clostridium difficile* bowel infection. Individual hospitals may have different rates, and the medical staff can tell you the risk for your hospital. You have a higher risk if you have had:

- long-term drainage tubes (e.g. catheters);
- bladder removal;
- long hospital stays; or
- multiple hospital admissions.

What can I expect when I get home?

- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- you may get some pain in your wound which can usually be relieved by simple painkillers
- you will be discharged with a catheter in your bladder; we will show you how to manage it at home
- we will arrange for you to come back into hospital to have your catheter removed; it is common to do a dye X-ray first to be sure your bladder has healed completely

- for the first six weeks, you should avoid any strenuous activity or heavy lifting
- after six weeks, you may return to everyday activities; if you do a very strenuous job or partake in strenuous exercises such as running or gym work, you should wait for longer and start gradually
- you will need at least three weeks off work; you may need longer if you have a strenuous job (your surgical team will be able to advise you about this)
- you should avoid sexual intercourse for six weeks after the procedure

General information about surgical procedures

Before your procedure

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (e.g. warfarin, aspirin, clopidogrel, rivaroxaban, dabigatran);
- a present or previous MRSA infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone treatment).

Questions you may wish to ask

If you wish to learn more about what will happen, you can find a list of suggested questions called "[Having An Operation](#)" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

Before you go home

We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

Smoking and surgery

Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local [NHS Smoking Help Online](#); or
- ring the Smoke-Free National Helpline on **0300 123 1044**.

Driving after surgery

It is your responsibility to make sure you are fit to drive after any surgical procedure. You only need to [contact the DVLA](#) if your ability to drive is likely to be affected for more than three months. If it is, you should check with your insurance company before driving again. You should not drive until you can move safely around the car and perform emergency braking without any pain.

What should I do with this information?

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for your own records or for your hospital notes.

What sources have we used to prepare this leaflet?

This leaflet uses information from consensus panels and other evidence-based sources including:

- the [Department of Health \(England\)](#);
- the [Cochrane Collaboration](#); and
- the [National Institute for Health and Care Excellence \(NICE\)](#).

It also follows style guidelines from:

- the [Royal National Institute for Blind People \(RNIB\)](#);
- the [Information Standard](#);
- the [Patient Information Forum](#); and
- the [Plain English Campaign](#).

DISCLAIMER

Whilst we have made every effort to give accurate information, there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

PLEASE NOTE: the staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you have any questions, you should contact your Urologist, Specialist Nurse or GP in the first instance.