

RESEARCH ARTICLE

ASSESSMENT OF TYPE AND CLINICAL FEATURES IN FEMALES WITH OBSTETRIC FISTULA - A CLINICAL STUDY

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ARTICLE DETAILS

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ABSTRACT

Obstetric fistula is an injury that occurs during prolonged and obstructed labor causing tissue damage to organs inside the pelvis and resulting in urine and fecal incontinence or both. The present study was conducted to record type and clinical features in females with Obstetric fistula. 60 patients with Female genital fistula were involved. A thorough clinical examination along with types and clinical features were recorded. Age group 10-20 years had 14 patients, 20-30 years had 26, 30-40 years had 12 and >40 years had 8 patients. The difference was significant ($P < 0.05$). Type of fistula was VVF in 48, RVF in 7 and RVVF in 5 cases. Clinical features comprised of urine incontinence in 38, fecal incontinence in 20 and both urine and fecal incontinence in 2 cases. The difference was significant ($P < 0.05$). Most common cause was VVF and RVVF. Clinical features comprised of urine and fecal incontinence.

KEYWORDS

fecal incontinence, Obstetric fistula, Urine

1. INTRODUCTION

Obstetric fistula is an injury that occurs during prolonged and obstructed labor causing tissue damage to organs inside the pelvis and resulting in urine and fecal incontinence or both (Dekidder et al.). obstetric fistula remains a major public health problem in areas where unattended obstructed labor is the common most frequently reported global prevalence of obstetric fistula shows that approximately 2 million women have untreated fistula and approximately 100,000 women developed fistula each year (Semere and Nour, 2008).

Female genital fistula (FGF) is a tragedy of the developing world because of illiteracy, poverty, ignorance, and lack of health facilities (Woaldijik, 1991). In developed nations, FGF occur most commonly as a result of gynecologic surgery and less commonly by infections, malignancies, radiation injury, sexual violence, and harmful social practices or obstetric trauma. Fistula as sequela of neglected labor, or obstetric fistula (OF), occurs almost exclusively in developing nations, where access to intrapartum clinical care is limited compared to that for women living in affluent nations (Wall et al., 2005). Optimal fistula programming is based on the principle that all fistula warrant hypervigilant attention to the details of patient preparation, meticulous reconstructive surgical technique, and rigorous postoperative care paradigms, regardless of whether the fistula is of the misnomered "simple" type or the more complex, large, fibrotic variety (Vagenderhuysen et al., 2001). The present study was conducted to record type and clinical features in females with Obstetric fistula.

2. MATERIALS AND METHODS

The present study was conducted among 60 patients with Female genital fistula. All were informed regarding the study and their consent was obtained.

Data such as name, age, etc. was recorded. A thorough clinical examination along with types and clinical features were recorded. Results thus

obtained were subjected to statistical analysis. P value less than 0.05 was considered significant.

3. RESULTS

Table 1: Distribution of patients

Age group (Years)	Number	P value
10-20	14	0.04
20-30	26	
30-40	12	
>40	8	

Table 1 shows that age group 10-20 years had 14 patients, 20-30 years had 26, 30-40 years had 12 and >40 years had 8 patients. The difference was significant ($P < 0.05$).

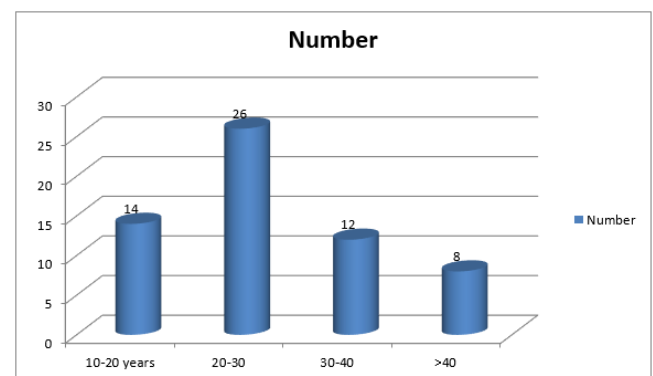


Figure 1: Distribution of patients

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Table 2: Type of fistula		
Type	Number	P value
VVF	48	0.01
RVF	7	
RVVF	5	

Table 2 shows that type of fistula was VVF in 48, RVF in 7 and RVVF in 5 cases. The difference was significant ($P < 0.05$).

Table 3: Assessment of clinical features		
Clinical features	Number	P value
Urine incontinence	38	0.031
Fecal incontinence	20	
Both urine and fecal incontinence	2	

Table 3, graph 2 shows that clinical features comprised of urine incontinence in 38, fecal incontinence in 20 and both urine and fecal incontinence in 2 cases. The difference was significant ($P < 0.05$).

4. DISCUSSION

Female genital fistula (FGF) occurs when open defects between the female genital organs and adjacent urinary and colorectal tracts create urinary or fecal incontinence. These defects, literally holes, allow the urine or stool to leak into the vagina. In developing nations, where pregnant women often give birth with minimal or no obstetric care, fistula most often occur as a result of several days of prolonged or obstructed labor (Muleta et al., 2007). These genitourinary or rectovaginal fistula (RVF) occurring after labor and its complications are labeled OF. Estimate suggested that at least 3 million women in poor countries have untreated VVF and that 30,000-130,000 new cases develop each year in Africa alone. An estimated 0.25% of total population of women suffer with untreated obstetric fistula the vast majority of obstetric fistula cases living in resources poor countries, and almost all of these injurers could have been avoided if timely and competent obstetric care was available, accessible and affordable (Asbahahaile, 2004). The present study was conducted to record type and clinical features in females with Obstetric fistula.

In present study, age group 10-20 years had 14 patients, 20-30 years had 26, 30-40 years had 12 and >40 years had 8 patients. Dereje et al in their study the total of 62 women was admitted. Out of the total respondent 90.32% were developed Vesicovaginal fistula, 22.25% were developed Rectovaginal fistula and 3.2% were developed Recto-vesicovaginal fistula (Dereje and Abebe, 2019). Majority of the respondents were from the rural area and 50% were in age group 20-24. 66.12% of the respondents had no regular antenatal care follow-up. Among the respondents 87.09% were primiparous. About 56.45% of the cases were caused by obstructed labor and 22.58% were caused prolonged labor.

We found that type of fistula was VVF in 48, RVF in 7 and RVVF in 5 cases. In developing countries, obstructed labor is one of the top five causes of maternal mortality, whereas in developed countries, obstructed labor is not allowed to progress ahead of a few hours. Women in developing countries still live with an inaptly high maternal mortality, with obstructed labor, hemorrhage, infection, hypertension, and unsafe abortion being the top five causes of death as a result of pregnancy (Muleta et al., 2007). Women who do not die from obstructed labor almost always suffer the dual devastation of a stillborn infant and problems resulting from the

obstructed labor, including OF, lumbosacral compression neuropraxia causing foot drop, and extensive vaginal fibrosis causing hardened vaginal walls or severe vaginal stenosis (Asbahahaile, 2004). When obstructed labor persists beyond 24 hours, maternal soft tissue edema, ischemia, necrosis, and sloughing of vaginal tissues occur due to the fetal head/presenting part becoming impacted against the bony pelvis and crushing vaginal soft tissue. This ischemic necrosis permits fistula and abnormal adhesions to form between the uterus and/or vagina and the adjacent urinary and colorectal organs that are also affected by the ischemia. These defects bypass the normal storage anatomic functions of the urinary and colorectal tracts, resulting in continuous incontinent flow of urine and/or feces (Tahzib, 1983).

A study conducted among 30,000 treated case from Addis Ababa fistula hospital over 33 years indicated that 97.4% of the age of the case was caused by obstructed labor out of which 63% of them were during first child birth (Kelly and Kwast, 1993).

5. CONCLUSION

Authors found that most common cause was VVF and RVVF. Clinical features comprised of urine and fecal incontinence.

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