On the reparative treatment of some of the graver forms of vesico-vaginal fistula / by Thomas More Madden.

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Vesico Vag. Fistula

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With the writer's compliments

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ART. XXII.—*On the Reparative Treatment of some of the Graver Forms of Vesico-Vaginal Fistula.*[a] By THOMAS MORE MADDEN, Obstetric Physician, Mater Misericordiæ Hospital; Consultant Obstetrician, National Lying-in Hospital; Physician, Hospital for Sick Children, Dublin; formerly Examiner in Obstetrics and Gynæcology, Queen's University, &c.

NOTWITHSTANDING the great advance of modern gynæcology, in no respect better shown than in the operative procedures by which vaginal fistulæ have been so generally rendered amenable to reparative treatment, the management of such cases in some exceptional instances still presents one of the most difficult problems that may occur in our special line of practice.

On the present occasion I do not purpose to refer to the ordinary forms of vaginal fistula consequent on parturition, and which are now less frequently met with as well as more amenable to ordinary operative treatment than was formerly the case. I shall, therefore, now confine myself to those graver as well as more exceptional cases in which more difficult procedures must be resorted to.

These cases may, I think, be roughly divided into two categories—firstly, those which, although some considerable loss of tissue has resulted from sloughing of the vesico-vaginal walls, are capable of repair by measures having for their object the bringing together and maintaining in apposition the separated parts until firmly consolidated by adhesive inflammation. In the second class may be included all cases in which the loss of substance or the position and character of the rupture are such as to preclude the restoration of the former structural integrity of the parts, and where either, by plastic operation, new vesico-vaginal or vesico-

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uterine walls must be built up, or else a new condition of the injured parts must be established.

With regard to the first class of cases, or where some degree of sloughing has followed long compression from delay in the second stage of labour, the main trouble in the operative treatment consists in keeping together the surfaces included in the sutures until they become united by new connective tissue, and in overcoming or preventing the disturbing influence of the retractile tension occasioned by the muscular structures of the vesico-vaginal walls, and the tendency to separation occasioned by their natural mobility. I need not here refer to the various mechanical expedients which have been designed for this purpose, as they are probably well known to the Academy; and, moreover, in the majority of instances, they are either unnecessary or useless, as their object may be generally accomplished by the division of any specially tense bands, or by merely nicking these at short intervals with the scalpel so as to allow them free expansion. In some few instances, however, I have found it necessary to employ the little instrument now shown, which is merely a modification of the late Mr. Baker-Brown's bar-splint for the purpose of lessening the tension on the sutures, and so hold the edges of the wound securely together.

Vesico-Uterine Fistulæ, if of less frequent occurrence, are obviously of greater importance and present much greater difficulties in their reparative treatment than those already referred to. In the comparatively exceptional cases of this kind that have come under my notice in hospital, in almost every instance the patient had been delivered instrumentally. Moreover, they most commonly occur in patients who have had a number of children, and who consequently have the abdominal parietes relaxed and the uterine walls softened and disintegrated by imperfect involution. In some instances they originate in lacerations of the cervix, extending thence across the roof of the anterior vaginal *cul-de-sac* into the bladder. And in such cases it is obvious that, even should the cervical laceration be healed over from below in the ordinary way, a fistulous communication would still remain above between the bladder and the uterine cavity or cervical canal, which must be subsequently dealt with.

Under these circumstances, therefore, we must either resort to tracheloraphy in the first instance, followed by a plastic operation on the vesico-uterine rent, or close the os uteri, so as

to convert this organ into an appendix to the bladder, through which the patient will afterwards menstruate, or else obtain a similar result by turning the cervix into the vesical cavity by the operation recommended by Dr. Goodell in some cases of this kind, which may be accomplished by denuding a portion of the cervical surface and uniting it to the vivified free edge of the fistulous opening. As a rule, neither of the latter operations should be resorted to whenever the former can be successfully performed, as their result should apparently be to render the patient capable of future gestation. In one remarkable case of this kind, however, in which Dr. Goodell's operation was anticipated by the late Dr. M'Clintock, the normal aperture of the uterus being thus closed; nevertheless, the patient afterwards again became pregnant, as it would appear through the urethra.

In cases of complete destruction of the anterior wall of the vagina involving the entire vesico-vaginal septum from the urethra to the base of the bladder, gynæcologists were formerly content to palliate the miserable condition of the patient by mechanical contrivances, such as a well-adjusted urinal belt. Recent experience has, however, demonstrated the feasibility of affording complete relief from the incontinence of urine in such cases by denuding the internal labial surfaces, and then closing them by sutures, so as to leave only a small aperture for the passage of urine, which can, if necessary, be controlled by a properly-adjusted spring trap or pad, and which, as will be seen by the following case, may not even require this. The advisability of such an operation in any instance is, however, another and a very difficult question, and most certainly it should never be undertaken without absolute necessity and after full consideration of all the possible consequences of converting the vaginal canal into a receptacle for urine—a condition entirely foreign to its physiological purpose, and one liable to be productive of grave ulterior results.

The objections to this operation have been very forcibly urged by one of the most eminent modern authorities on the subject; and as one of the objects of the present communication is to bring forward a case where I succeeded in relieving an otherwise incurable patient by the procedure thus condemned, I shall here, in the first place, recapitulate Dr. Emmet's views on this point. "There exists," he says, "no greater malpractice than the procedure which, we are told, was practised by that great master, the late Prof. Simon, of Heidelberg. He never seemed to appreciate the import-

ance of the principle which I am now endeavouring to impress upon the reader. Without hesitation he would shut up the vagina when difficulties presented themselves in bringing together the edges of a fistula, as if the sole object was to give a retentive power regardless of the consequences. From my own observation I have learned that it is but a question of a few months, a year, or possibly two, before serious consequences must arise after leaving a receptacle, like a portion of the vagina, in which the urine may stagnate. To give a retentive power for so short a time is not a sufficient compensation for the suffering and consequences which supervene. As the result of my experience, I would urge that the operation should never be resorted to under any circumstances. The maximum has now been reduced to two or three per cent. of cases where the resources of the surgeon cannot overcome all the difficulties which may be presented in closing a vesico-vaginal fistula. Something more may be accomplished in the future; but, at present, these incurable cases are better without the retentive power when gained by Simon's method. The surgeon endeavours to cause the parts to heal thoroughly, and educate the patient in the art of taking care of herself, and in this way much can be done to render her condition a comfortable one."

Whenever the destruction of tissues has been so extensive as to permit the inverted bladder, filled with intestines, to protrude from the labia in an almost strangulated condition, some surgical relief is imperative. In such cases I do not hesitate, with the consent of the husband, to unite the sides of the vagina at any point within the canal at which I can gain the needed support for the bladder. This is done to relieve the suffering attendant upon the prolapsed bladder, and it is very effectual. But I always leave an opening at the most dependent portion, and one above, so that the urine cannot accumulate, and the parts may at any time be washed out if necessary. After the surfaces have all healed, and the woman has learned to keep herself free from excoriations, her health will remain good, and the escape of urine will be comparatively but a slight inconvenience. Certainly no comparison can be drawn between the comfort of one with retentive power at the cost of cystitis and its consequences, and the other in a healthy condition, with the urine escaping into a cloth or some other suitable receptacle.

I go further than Dr. Emmet, and would say that it should, moreover, not be forgotten in this connection that in some

instances vesico-vaginal fistulæ of large extent may possibly be cured spontaneously or without any operative interference. I myself am cognisant of two such cases, in which the patients, in early life, had each suffered parturient laceration of the vesico-vaginal walls, and for many years subsequently endured the incontinence of urine and other discomforts consequent thereon. In both cases, in the course of time, these patients by the occurrence of senile atresia of the vagina at last become perfectly freed from any trace of the accident, the effects of which had rendered miserable the better part of their long lives. Such cases are, however, far too exceptional to have much practical influence in determining the adoption or non-adoption of any available plan of treatment in cases of vesico-vaginal fistula, such as the following. In this instance the ordinary method of treatment failed; and as the operation employed, although, perhaps, neither original in its conception nor approved by the highest authority, was successful, and is not often, if ever, here resorted to, I have thought its details might be worth bringing before the Academy.

Case.—K. B., aged forty, widow, six children, sent in by Dr. O'Brien, Johnstown Bridge; admitted November 12th, suffering from vesico-vaginal fistula and laceration of cervix of four years' standing. She was in a wretchedly cachectic state; her thighs and nates raw and excoriated by the constant urinary dribble, and thickly encrusted with sabulous deposit. The history of the case, as well as it could be ascertained—as she was an extremely stupid woman—was that until the birth of her last child she had enjoyed good health. Her labour was very protracted, extending, according to her own account, over sixty-nine hours, but she had no assistance beyond that of a neighbourly "handy woman." She states that the incontinence of urine was first noticed the day after delivery, but became much worse when she arose from bed, six days later, and had since continued. She sought no advice, however, until a month before admission, when she consulted Dr. O'Brien, by whom she was sent up to hospital. On examination the cervix was found extensively lacerated bilaterally, the rent extending from the anterior lip of the vaginal roof and down through the septum, and involving the entire of the base of the bladder. There was considerable loss of substance, apparently from sloughing. A few days after admission an attempt was made to close this large opening, in the usual manner; and with great difficulty, owing to the loss of tissue, its vivified edges were brought together. Unfortunately, however, although some union took place in the lower part of the wound, no substantial benefit followed this operation; and, hence, considering that under the existing

local circumstances and general condition of the patient, any further effort in the same direction would be equally unavailing, when she again returned (three months later) I resolved on trying a modification of Simon's operation for closing the vaginal aperture so as to form a new receptacle for the urine. With this view a superficial incision was cautiously made, extending elliptically through the vaginal mucous membrane from above the meatus anteriorly round the canal to its posterior commissure behind the nymphæ, and thence dissected off the subjacent structures and removed, so as to leave an extensive raw surface. A great deal of venous hæmorrhage took place during this, which was arrested by hot water and turpentine, whilst a few small spouting arterial branches were twisted or ligatured. When all hæmorrhage had been thus arrested the denuded surfaces were brought together by silver wire sutures, so as to completely close the passage from the vaginal orifice upwards. The vulva was sealed with aseptic dressing, leaving merely an opening for the retaining catheter, and secured by a pad and a bandage. On the next day she complained a good deal of pain and soreness, which was relieved by opiates, but beyond this her recovery was uninterrupted, the temperature never rising above 100°. The catheter, being a railroad one, was changed and cleaned daily, without disturbing the dressing, until the eighth day, when the sutures were removed and the parts found united. Her bowels were then cleared by an enema, the vulval dressing replaced, and the catheter continued for another week, at the end of which it was finally withdrawn, and she was then found to have complete retentive power in the recumbent position, though when standing there was still a slight dribble from the dilated urethra, which gradually lessened, and after leaving the hospital I heard that she had no vestige of this trouble, from which she remained free until her death, from fever, eighteen months later.

In conclusion I may repeat that, whilst regarding my modification of Simon's operation for closure of the vagina merely as a *dernier ressort*, to be adopted only in the treatment of some exceptional cases of vesico-vaginal fistula otherwise incurable, nevertheless the procedure appears to me to deserve some consideration in such cases. I yield to no one in my respect for Dr. Emmet's authority on this subject, but I would not myself be deterred even by his condemnation from again reverting in any similar instance to the operation by which I benefited the patient whose case has been just related. Whether any renal disease, such as Dr. Emmet insists on as the consequence of Simon's operation, supervened in my case or not I have no data to say. I only know

that a patient whose condition had for years previously been as miserable as any that could well befall a woman, and who to the best of my opinion was otherwise incurable, was by the operation described restored to a state of comfort and apparent health (which lasted for at least some time) subsequently.