

# Vesicovaginal Fistula - More Than An Obstetric Problem

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Obstetric vesicovaginal fistula due to obstructed labour has long been eradicated from the developed world<sup>1-3</sup> but it remains a major problem in developing countries like Pakistan<sup>4</sup>. Here underprivileged women still develop vesicovaginal fistula following obstructed labour. The poorest of poor women living in remote rural farming areas being more likely to do so<sup>5</sup>. Most reports on fistula, concentrate on surgical aspects. It is an issue that requires consideration of economic, social and cultural factors, a chain of events leading to its formation and the miserable status of the afflicted woman.

Obstetric vesicovaginal fistula has been termed an ailment of the young primigravida<sup>6-8</sup>, with the majority of patients from various developing countries<sup>7-9</sup>, including Pakistan three decades earlier<sup>10</sup> being primiparous. However, recently more multiparous women than before, in Pakistan develop urinary fistulae following labour<sup>8</sup>. This is attributed to osteomalacia of the pelvis after repeated childbearing and lactation, another sad reflection on the nutritional status of these women. Also increasing parity is associated with increasing birthweight<sup>11,12</sup>, leading to foetopelvic disproportion not encountered previously.

With more multiparous women than before presenting with fistula, one would think that if women were to limit the size of their families, complications including fistula formation could be reduced. Health and Family Planning services in rural areas of Pakistan even if available, are seldom utilized. One discouraging reason being the high infant mortality rate. Despite high parity some of these women have no live issue. These women, after successful repair, go back to the same circumstances that resulted in fistula formation. This is reaffirmed by the fact that some return with recurrence following subsequent labours in the same setup. It is time the emphasis is shifted from curative to preventive strategies<sup>9</sup>.

Only 11% of women in the subcontinent receive any antenatal care and 85% of deliveries are conducted at home by relative or untrained traditional birth attendants<sup>13</sup>. Women are left in labour for long hours. This reflects poorly on the availability and utilization of medical services. Only a third of the rural population lives within 5 km or an hour's walk from a fixed health facility<sup>13</sup>. Transport problems and difficult terrain make matters worse<sup>3,8</sup>. Even if a healthcare facility is available, it may not be availed. Labour is considered a physiological event<sup>7</sup>, the women themselves mistrust the unfamiliar hospital environment<sup>8</sup>. They do not wish to be attended to by males, who may be the only health personnel available there. If the husband happens to be away, the woman herself or the other family members cannot make the decision to take her to hospital<sup>14,15</sup>. The attitude of the family and society towards life and women are significant obstacles<sup>16</sup>. The impact of these factors is also evident in the long interval between development of fistula and presentation to hospital for treatment.

Fistula surgery is undertaken in major hospitals in cities and patients often travel great distances to get there. Preparation for surgery and postoperative care of a fistula patient takes time, a commodity which the accompanying relatives find difficult to sacrifice. Public hospitals, overwhelmed by emergency obstetrics and long waiting lists, give fistula patients a low priority<sup>1,8</sup>. At times the cost of subsistence in a big city is beyond their means and family members are unwilling to 'leave the woman on her own in the city', even for treatment in hospital, forcing her to return untreated to her previous miserable existence. This is a sad reflection on the status of women in society, the root of the problem in the first place.

Of those who are cured, few return for follow-up. Infertility and dyspareunia due to vaginal fibrosis, are

separate issues worthy of follow-up and rehabilitation<sup>17</sup>. It is not surprising that some women do not regain their self esteem despite a cure<sup>16</sup>.

Epidemiological studies in the community are required to determine factors responsible for obstructed labour and determine strategies for prevention of fistula. Hospital figures are not indicative of prevalence<sup>1</sup>. For every woman who manages to reach hospital for treatment, possibly many more suffer in silence, hidden away leading ostracized lives<sup>3,5,8,16</sup>. not even aware of a possibility of cure<sup>8,18</sup>.

Unlike other neighboring countries, the size of the problem in Pakistan remains unchanged<sup>8</sup>. There are no shortcuts to solutions. Eradication of illiteracy<sup>19,21</sup> and change of society's attitude towards women for the better<sup>16</sup> are fundamental for a favourable change.

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