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Case Report

REHABILITATION OF A PATIENT WITH EXTENSIVE URINARY TRACT INJURY FOLLOWING MANAGEMENT OF DUAL MALIGNANCY

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ABSTRACT

Dual malignancies with post surgical complications pose a challenge to the surgeons and needs proper planning to achieve a good result.Here is a Case report of a patient with cancer cervix and anal cancer who underwent Wertheim's hysterectomy for cancer cervix and presented to us with bilateral ureteric injury cobined right ureterovaginal &vesicovaginalfistula.She was managed with bilateral percutaneous nephrostomy for 2 months. Radiotherapy&chemotherapy was given for analcancer. later she was taken up for bladder augmentation with transverse colon and bilateral ureteric reimplanatation .Due to leak from anastamosis , revision surgery was done and transverse colon made into cutaneous conduit**.**

Key words-vesicovaginal fistula,wertheim's hysterectomy,cutaneous conduit

INTRODUCTION

Vesicovaginal fistula(VVF) are the most common acquired fistula of the urinary tract.VVF combined with ureterovaginal fistula is very rare . The etiology differ in various patient of world, the most commonest cause of VVF is injury to the bladder at the time of gynaecological , urological or any pelvic procedures. Hysterectomy is the commonest cause for surgical injury to the urinary tract. The incidence of bladder injury after hysterectomy is around 0.5-1% and for fistulas 0.1 to 0.2%. Hence we present a case of combined ureterovaginal and VVF which patient developed following Wertheim's hysterectomy. Patient was managed by bilateral PCN followed by bladder augmentation with transverse colon conduit and bilateral ureteric reimplantation.

CASE REPORT:

46 years old female a K/C/O of post Wertheim's hysterectomy with carcinoma posterior wall of anal canal came with C/O urinary leak through vagina in the immediate post operative period suggestive of genitourinary fistula.Histopathology of both tumours were squamous cell carcinoma . On evaluative USG and CT-KUB showed bilateral hydroureteronephrosis with contrast extravasation from right ureter (fig2).serum creatinine was 1.6mg% Cystoscopy revealed right lateral bladder wall defect involving rt ureter .left ureteric catheterization was not possible. urinary diversion was done through bilateral percutaneous nephrostomy (fig1).renal parameters came to normal.

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Repeat cystoscopy was done after 2 months bladder wall well healed with with no urinary leak. Patient was planned for bladder augmentation with transverse colon and bilateral ureteric reimplantation(fig3). Transverse colon was preferred in view of previous radiotherapy given for management of carcinoma anal canal (fig4). Patient withstood the procedure well. Post operative period was uneventful. On 14th post operative period antegradepyelogram study was done, which was normal following which bilateral PCN& ureteric catheter removal was done.On 16th POD SPC, urethral foley and suture removal was done. At the time of discharge patient voided through natural orifice. After one month patient came back with urinary leak, PV and cystoscopy revealed recurrent VVF, patient was then taken up for augmentation revision and transverse colon is brought out as cutaneous urinary conduit .patient is currently on followup and is doing well.

Fig.1 Antegrade pyelogram with blind ending ureters

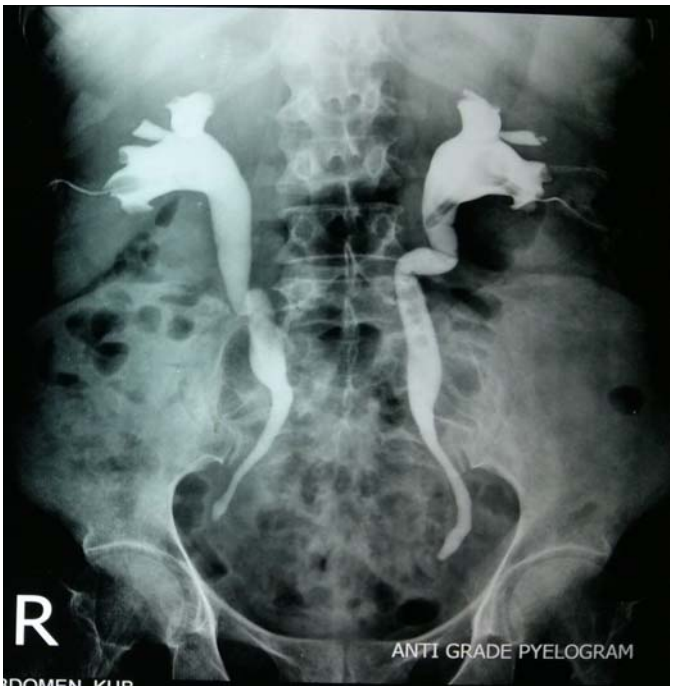

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Fig.2.IVU showing contrast extravasation from right ureter

Fig.3.Right RGP after bladder augmentation with transverse colon and bilateral ureteric reimplantation

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Fig.4.CT showing anal growth

DISCUSSION:

Radical hysterectomy needs dissection of entire pelvic ureter damaging the blood supply(2) ischemic damage is more common than direct injury(1).commonest location is in lower ureter. Incidence of ureterovaginal and vesicovaginal fistula is 0.6-6.6% Fistula appears between twelth and thirteenth postop day.prominent signs are urinary leak,fever,lower abdomen mass.After urinary diversion definitive procedure should be delayed for 3-6months for spontaneous closure and goodwound healing (2).In postirradiated patients chances of anastamotic leakage and stricture formation are more (2,3)hence cutaneous urinary diversion is better than bladder augmentation . The oncogenic viruses like Human Papilloma Virus (HPV) 16 and 18 have been implicated in the development of cancers of the cervix and anal canal and an increased risk occurs in Human Immunodeficiency Virus-infected (HIV) individuals(8). Dual malignancies involving cervix and breast are common .There were various factors which emphasized the prevention of VVF during gynaecological procedures

1. Immediate detection of bladder injuries
2. Water tight closure of the bladder
3. Satisfactory extravesical drain placement
4. Prolonged uninterrupted post operative bladder drainage

Management of VVF requires a proper abdominal and pelvic examination. The goal in the management of VVF is the rapid cessation of urine leakage with return of normal and complete urinary and genital function

CONCLUSION

Dual malignancies need multimodality management.staged treatment is preferred in urinary fistulas following cancer surgery .Ideal waiting time is 6months following

urinary diversion.Reconstuctive procedures have poor outcome and should be done with extreme caution and reservation when compared to cutaneous conduits.

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