International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Cortés DCP et al. Int J Reprod Contracept Obstet Gynecol. 2024 Nov;13(11):3338-3339
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20243202

Case Report

Vesicocervical fistula: a case report

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Received: 15 September 2024
Accepted: 10 October 2024

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ABSTRACT

We present a case report of a vesicocervical fistula in a 70-year-old female with history of caesarean section forty-five years prior to clinical presentation, she presented referring continuous vaginal urinary incontinence of a couple of years of evolution, the diagnosis of delayed presentation vesicocervical fistula associated with a caesarean section was reached by exclusion, after ruling out infectious or malignant pathologies. An abdominal approach with hysterectomy and extra vesical fistulectomy was performed without any complications during the procedure. At follow-up blue dye test was negative and continuous urinary incontinence resolved. We present an alternative management of an extremely rare presentation of urogenital fistulae.

Keywords: Vesicocervical fistula, Fistula, Urogenital fistulae

INTRODUCTION

Vesicouterine fistulae (VCF) are an uncommon type urogenital fistula presentation. VCF are even more infrequent. They represent approximately 1 to 4% of all urogenital fistulas, they usually arise in the context of gynecological surgery like hysterectomy, or obstetric events such as caesarean section or forceps delivery, other etiological factors such as endometriosis, carcinomas and radiotherapy.[1-3] In the few cases described, the clinical presentation is almost immediate to the attributable cause. The case presented here is even more unusual because the patient was asymptomatic until late postmenopause.

CASE REPORT

We present the case of a 70-year-old female, with history of caesarean section 45 years ago secondary to labor arrest. She presented to us for referring continuous vaginal urinary incontinence of 2 years of evolution. With no medical history of use of forceps, uterine instrumentation, gynecological surgery, hematuria and constitutional symptoms. Speculoscopy showed urine pool, and then a blue dye test was performed, and it was positive (Figure 1).

Figure 1: Positive urine pool and blue dye test.

A pap smear test and endometrial biopsy were performed to rule out malignant pathology, and both were negative. Magnetic resonance imaging (MRI) revealed contrast medium passing through the vagina with an 8 mm defect towards the uterus (Figure 2) and ruled out the presence of tumors. Cystoscopy-hysteroscopy showed communication from the bladder (Figure 3) to the endocervical canal below the inner cervical os; methylene blue dye to ruled out communication with the uterine cavity, and no tumors were observed (Figures 4a and b). Biopsy of the fistulous

tracts was negative for malignancy and urogenital tuberculosis. The diagnosis of delayed presentation VCF associated with a caesarean section was reached by exclusion.

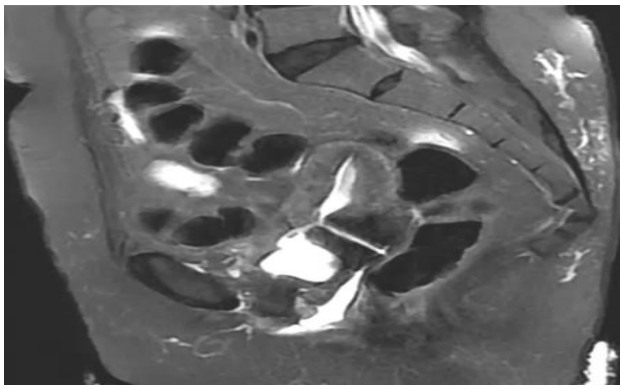

Figure 2: MRI with passage of contrast from bladder to cervix.

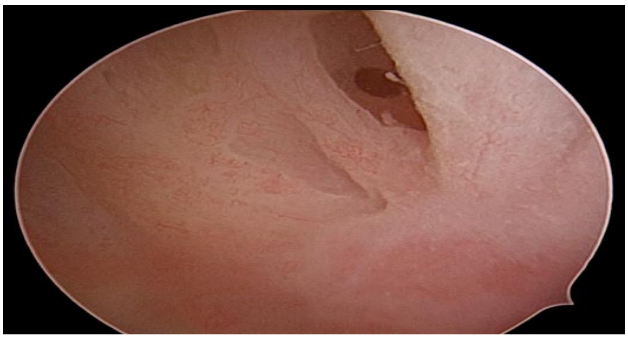

Figure 3: Cystoscopy demonstrating fistulous tract.

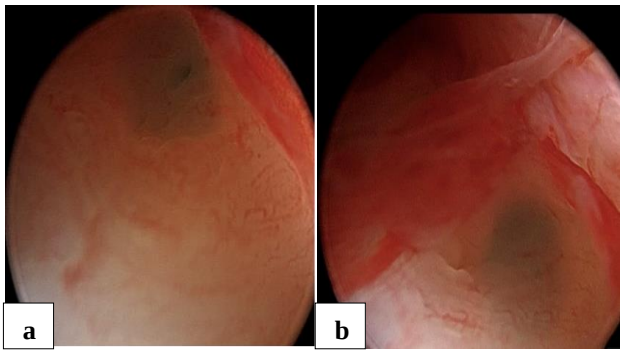

Figure 4: (a) Hysteroscopy demonstrating outflow of methylene blue into endocervical canal, and (b) hysteroscopy showing the passage of the dye just below the inner cervical os.

Although vaginal repair has been described for this condition, an abdominal approach with hysterectomy and extra vesical fistulectomy was planned, and local oestrogens treatment at discharge. At 12 weeks follow-up blue dye test was negative.

DISCUSSION

VCF represent approximately 1 to 4% of all urogenital fistulas.[1] They usually arise in the context of gynecological surgery or caesarean section, with other etiological factors such as endometriosis, carcinomas, and radiotherapy.[2,3] The presentation can be acute or delayed, depending on the injury mechanism.[4] Most cases occur during caesarean sections.[5] The case we present is atypical because the patient remained asymptomatic for 45 years after the caesarean section, with no association to other pathology. Patients with VCF located above the inner cervical os, present cyclical menouria without urinary incontinence due to the closing action of the uterine isthmus.[2] It is likely that the hysterotomy was performed at the most distal part of the uterine segment, very close to the cervix. The bladder may have adhered to the uterine scar due to inadequate dissection of the vesicouterine fascia, or sutures may have inadvertently passed through the bladder compounded by hypoestrogenism, which may have caused silent dehiscence and the creation of a VCF.[1]

CONCLUSION

VCF as a late-onset presentation secondary to a caesarean section is extremely rare. This pathology could be avoided with intraoperative identification in the presence of suspected bladder injury.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Cortés DCP, Cabrales FM, Penilla LFR, González AC. Vesicocervical fistula: a case report. Int J Reprod Contracept Obstet Gynecol 2024;13:3338-9.