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Maioli R[1], Garcia A[1], Macedo A[1], Almeida S H[1], Souza A P[1], Tashiro R[1], Rodrigues M A[1]
1. Universidade Estadual de Londrina

LAPAROSCOPIC REPAIR FOR VESICOUTERINE FISTULAE

Introduction:
The vesicouterine fistulae (VUF) comprise 2-9% of all urogenital fistulae. Only 5% of the patients respond to conservative management, and the rest of them needs definitive surgical repair (1).Laparoscopy provides better visualization through magnification, but is more difficult to learn, as is intracorporeal suturing. Our hypothesis is that achieved with other pelvic laparoscopic procedures, such as ureteral reimplantation, correction of vesicovaginal fistula and radical prostatectomy; allows the urology resident ability to perform the procedure with traditional laparoscopic intra-corporeal suturing, without any special tool.
Design:
The purpose of this video is to present a laparoscopic repair of vesical-uterine fistula performed by a resident of urology. Female, 42 years old, with gross hematuria in the immediate postoperative cesarean delivery. The obstetric team chose for conservative management. She developed intermittent hematuria and cystitis. Hysterosalpingography and pelvic computed tomography scan showed a fistula. The cystoscopy revealed ulcerated lesion in the bladder dome of approximately 1.0 cm.
Results:
The patient was placed in the lithotomy position with extreme trendelenberg. Pneumoperitoneum was created using a Veress needle in the midline infra umbilical and the primary 11 mm. port was placed. Another one 11-mm port was inserted midway between the left superior iliac spines and the umbilicus. Two others 5-mm. port was created under laparoscopic vision in the iliac fossa at both sides. Omental adhesions in the pelvis were carefully taken down, the peritoneum between the bladder and uterus was incised using a cautery. Limited cystotomy was made, the exact site of the fistula and the ureteral meatus were identified and the posterior bladder wall was adequately mobilized from the uterus. The uterine rent was closed by a single 3/0 Vicryl sutures. Two-layer watertight closure of the urinary bladder was done using 3/0 Vicryl sutures. A flap of omentum was mobilized and inserted between the uterus and the urinary bladder, fixed with two 3/0 vicryl sutures and tube drain was inserted. Operative time was 140 min with blood loss of 100 mL. The patient was discharged on third post-op. day and catheter was removed on 10th day.
Conclusion:
Laparoscopy has advantages over open surgery in producing less pain, shorter hospitalization, better cosmesis, quicker recovery and equal efficacy. Although the fistula vesical uterine is rare, laparoscopic skill obtained with other urological procedures, allows defining the laparoscopic repair as the procedure of choice for such cases (2). The reported operative time for laparoscopic repair of VUF in the literature varied between 140 and 220 min (3). Laparoscopic should be considered a mode of abdominal access and should not influence method of surgical repair. Surgical success should depend on adherence to good technique rather than approach. It appears to be a viable alternative for surgeons experienced with laparoscopic suturing techniques.

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