Editorial

Towards a solution for obstetric fistula problems

I thank the Editors of Pelviperineology for this invitation to write an editorial as background to our **Interim Report on a new method for fistula surgery**, which was first proposed in this journal in 2015.

The background is that despite the efforts of the Millenium Development Goals and recent advances in maternal health across the world, far too many women are still dying in labour and many women are still getting injured.

The obstetric fistula is one of the most feared injuries and there are an estimated 2 million women across the world still waiting for treatment.

There is a growing number of surgeons being trained and more women getting treated. But the surgery is not a guarantee of cure. Fistula patients vary considerably in the type of injuries they sustain and what type of surgery is needed to reconstruct the urinary tract, reproductive tract and gastrointestinal tract. Closing the defects is one thing and over 95% of women can have their fistula closed at the first operation by a skilled surgeon. However, up to 55% of patients will still have ongoing incontinence. This problem of ongoing incontinence has been underreported and even neglected. Many places just perform a dye test and if it is negative the patients are recorded as cured, *even if they are still leaking the same amount as before the operation*. The harder you look for the problem, the more you will find. It is the author's routine to examine all patients with a full bladder, get them to cough, walk and for the more severe cases quantify the loss with a one hour pad test. Accurate diagnosis is of critical importance. Those patients who remain wet become depressed, suicidal with little or no chance of having a normal life. Many, very many, live out their lives as outcasts from family and home.

There have been several different operations described to tackle the problem. The general principles of urinary incontinence in the west are not readily transferable as the pathology is different. The patients with ongoing incontinence invariably have had some damage of their urethra during the fistula formation, sometimes the whole urethra along with half the bladder has been destroyed along with the vagina and despite complex reconstructive surgery, they are still wet.

Some have tried tape slings, but with poor results and high erosion rates. Nearly all hospitals performing fistula surgery cannot afford synthetic slings anyway. Autologous slings, muscle or fascia are cheap and so are used more widely, but it is not the answer. For the most severe cases the cure rate is a pitiful 26%.

Our introduction of a skin flap to restore vaginal elasticity has shown a big jump in the success rates in women *that would have been labeled as having an extremely poor prognosis or even inoperable*. We could expect even greater outcomes in all patients with vaginal tissue loss.

This Interim Report is the endpoint of a classic scientific journey. Guided by the Integral Theory, an analysis was made of the pathogenesis; a hypothesis was formed, that the problem was scar-induced loss of vaginal elasticity. From this evolved treatment, application of a skin graft to improve tissue elasticity. This was tested in a small pilot study. Then the skin graft method was applied to the worst affected cases, the basis of our Interim Report. In summary, this technique marks the most exciting advancement in fistula surgery for many years and many thousands of impoverished women stand to benefit.

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