



A SIMPLIFIED LAPAROSCOPIC APPROACH TO REPAIR VESICOVAGINAL FISTULA: THE M.S. RAMAIAH TECHNIQUE

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Vesicovaginal fistula (VVF) is an extremely distressing problem to patients in view of its physical, psychological, and social dimensions. The transvaginal and the abdominal routes are the 2 approaches currently in vogue for the repair of VVF (1). Laparoscopic repair is now a well-established modality in the management of VVF, with its safety, feasibility, and efficacy with a good success rate and less morbidity (2). The objective of the present study is to describe a simplified laparoscopic approach for the management of VVF, with the specific aim of decreasing laparoscopic intracorporeal suturing and to results with this simplified approach.

SURGICAL TECHNIQUE

The patient was intubated and placed in lithotomy position. The vagina was packed with wet roller gauze to maintain the pneumoperitoneum during the course of the procedure. A 10-mm camera port was placed at the upper lip of the umbilicus. A 10-mm working port was placed at the midpoint of the right spino-umbilical line, and another 5-mm working port was placed similarly on the opposite side. The lithotomy was maintained, but the table was tilted to a steep Trendelenburg position. Adhesiolysis was performed. The bladder was filled with 200-mL saline, and Foley catheter was clamped. A sponge stick was inserted into the anterior fornix of the vagina. The peritoneum between the bladder and the vagina was opened. The partially filled bladder and the sponge stick in the vagina help to orient the dissection accurately. A limited cystotomy was performed using hook electrocautery and extended to include the fistula. By sharp dissection,

the bladder flaps were dissected free from the vagina. The vaginal opening was not closed separately but covered with an omental flap that was held in place with a single bite of 3-0 V-Loc barbed suture (Covidien, Mansfield, MA) taken through the distal apex of the vaginal opening. The cystotomy was sutured with a single layer of continuous 3-0 V-Loc barbed suture. The integrity of the suture line was tested by filling the bladder with 300 mL of normal saline mixed with methylene blue. A suprapubic cystotomy was not used in any case, and no drain was placed.

A total of 22 patients were included in the analysis. The mean operative time was 75 minutes (range, 55- 100 minutes). The mean estimated blood loss and hospital stay was 35 mL and 1.5 days, respectively. There were no intraoperative complications. One patient had postoperative paralytic ileus. All patients were continent after catheter removal on postoperative day 14. All patients remained symptom free in the follow-up period, which ranged from 2 to 45 months (mean, 18 months).

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Laparoscopic repair of VVF is an excellent alternative to traditional open repair. However, it requires familiarity with pelvic anatomy and experience of free hand intra-corporeal suturing. Single-layer bladder closure with V-Loc barbed suture, and omental patch of the vaginal opening produces seems to be good option to VVF repair.

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