CASE REPORT

Vesicovaginal fistula due to vaginal herb for primary infertility: could it be devastating?

Sagorika Paul, Vishwajeet Singh, Rahul Janak Sinha, Arvind Kumar

Department of Urology, King George Medical University, Lucknow, Uttar Pradesh, India

Correspondence to

Dr Sagorika Paul,
dr_sagorika1612@rediffmail.
com

SUMMARY

Vesicovaginal fistula (VVF) is a very commonly encountered urogynaecological entity in developing countries such as India. The most common cause of VVF in developing countries is secondary to obstructive labour. We report a very unusual case of VVF in a young woman that developed due to insertion of an unknown vaginal herb for treatment of primary infertility. Cystoscopy showed a single trigonal fistula measuring 3×2 cm just near the bladder neck. Vaginoscopy revealed cicatrised less capacious vagina and unhealthy vaginal mucosa. She was treated with transvaginal VVF repair using Martius flap interposition which leaked on 10th postoperative day. She underwent re-evaluation and another transvaginal fistula repair for small trigonal residual fistula after 3 months. She is doing well during the follow-up of 2 years. She attained sexual activity after 3 months of surgical repair but could not conceive.

BACKGROUND

In developing countries prolonged obstructed labour is responsible for vesicovaginal fistula (VVF) accounting about 1–3/1000 deliveries in West Africa.¹ The reported incidence of VVF in selected pockets of population in India is 0.3–0.5%.² VVF is a distressing condition that significantly impairs physical, psychological, social and sexual health.³ The less common causes include accidental injury at the time of caesarean, forceps delivery and traditional surgical practices. We report an unusual case of a 28-year-old married woman who presented to us with continuous dribbling of urine from vagina following self-application of a vaginal herb prescribed by untrained local non-medical personnel for primary infertility.

CASE PRESENTATION

A 28-year-old married illiterate woman from a remote area had history of primary infertility for 6 years. On the advice given by her friends and relatives she visited to local untrained non-medical personnel. They inserted some herbal medication into her vagina for 12 consecutive days with the aim of treating primary infertility. The constituents of the herb were not known but it was in the form of dried green pellet made of herbal extract. After 7 days of postinsertion of herb therapy she developed high-grade fever and severe burning sensation in the vagina followed by the sudden onset continuous leakage of urine with a minute amount of blood through the vagina. Then she went to a primary health centre where she was being symptomatically treated and referred to us for definitive management.

There was no history of faecal incontinence. She gave a history of irregular menstruation. There were no associated comorbid conditions.

INVESTIGATIONS

Except mild pallor the physical examination was unremarkable. On examination the external genitalia was absolutely normal and there was gross leakage of urine from vagina. The vaginal examination revealed stenosed and scarred vagina, ill-defined cervix and a large defect on anterior wall of the vagina. Speculum examination showed large defect of approximately 3×2 cm in size and the cervix was densely adherent to the posterior vaginal wall (figure 1). The vaginal length was assessed which was 5.5 cm (figure 2). The vagina mucosa was thick and cicatrised. The digital rectal examination was normal.

An ultrasound of pelvis showed a normal upper tract and a normal uterus and ovaries and absence of any adnexal mass. Cystoscopy showed single 3×2 cm trigonal VVF just above the bladder neck. The bilateral ureteric orifices were normal with clear efflux. Vaginoscopy showed a stenosed and cicatrised short vagina and confirmed the presence of fistula on the anterior wall of the vagina. After adequate assessment of VVF secondary to vaginal herb insertion, she was counselled and advised for transvaginal fistula repair.

TREATMENT

The patient underwent transvaginal VVF repair using Martius flap interposition. There was no

Figure 1 Stenosed cervical opening, cicatrised vagina and cervix adherent to vaginal wall (depicted by red arrow).

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Figure 2 Short vaginal length.

intraoperative complication. On 10th postoperative day onwards she presented with watery discharge from the vagina. On gentle examination, leakage of urine from vagina was seen. She was discharged home with advice for next transvaginal VVF repair after 3 months. The reassessment of residual fistula was performed by cystoscopy and vaginoscopy. It revealed small single residual fistula at the trigone approximately 0.5×0.5 cm in size. She subsequently underwent another transvaginal VVF repair with Martius flap interposition. She was discharged on the 15th postoperative day with a Foley catheter and a suprapubic catheter in situ with advice to follow-up after 2 weeks.

OUTCOME AND FOLLOW-UP

The patient was continent after removal of the Foley catheter after 4 weeks of operation and this was followed by supra pubic catheter removal on a later date. She was being followed up every three monthly for first year and biannually in second year. After that, she was lost on subsequent follow-up. The vaginal speculum examination revealed normal introital calibre and shortening of vaginal length (6 cm). There was stenosed cervical opening and cervical lips were plastered to vaginal wall). She also attained normal menstrual cycles after taking treatment by a gynaecologist. She experienced mild dyspareunia following surgical repair for which she was taking treatment from a gynaecologist. She was doing well in 2 years of follow-up but still she has not conceived.

DISCUSSION

VVF is a distressing condition that profoundly impairs physical, mental, sexual and social life.³ In developed countries, the most common antecedent event causing VVF is hysterectomy (abdominal/transvaginal) accounting 75% of fistulae.^{4–5} In developing countries prolonged obstructed labour is the most common cause followed by less common causes such as accidental injury at the time of caesarean, forceps delivery and traditional surgical practices. VVF caused by erosion of a foreign body such as a pessary or vigorous intercourse has also been reported in the literature.^{6,7}

VVF as a consequence of vaginal insertion of herbal medications is rare in the English literature. Basak and Bag described the use of herb in a 62-year-old woman, who applied a pasty material over her prolapsed vagina and subsequently developed VVF.⁸ Similarly Adaji *et al* described VVF and vaginal stenosis following insertion of herbs into her vagina by a traditional doctor to melt her uterine myomata. She underwent successful transabdominal repair of fistula and passive dilation of vagina was recommended for the vaginal stenosis.⁹ Another case of

VVF following use of vaginal herb in young girl for uterine fibroid was described by Igberase *et al*.¹⁰

In the present case the VVF might have developed due to traumatic insertion of herb into the vagina associated with severe inflammatory reaction. In developing countries such as India poverty, illiteracy, unawareness of medical facilities and ignorance of women in low income families, are the potential barriers to access to healthcare. In addition, the sturdy orthodox sociocultural beliefs in the remote areas are stigma to the society. Most of the ailments and even deliveries are being treated by local untrained traditional practitioner. In this case if the young woman would have gone to health centre for primary infertility then she could not have suffered from this complication. She was already suffering from mental and social stress due to primary infertility and development of VVF superadded on to it.

This complication can be prevented by educating the women folk about harmful health practices, recruitment of trained medical practitioners in remote areas and strict laws to abolish medical malpractices. In conclusion, we report a case of VVF and vaginal stenosis in a young woman following vaginal herb insertion by local untrained medical personnel for primary infertility. Despite the presence of a healthcare system, people from remote areas are not beneficiaries due to poverty, illiteracy and social ignorance of the women in low income families.

Learning points

- ▶ Development of vesicovaginal fistula following vaginal herb is rare.
- ▶ Poverty, illiteracy and social ignorance of women are prime factors responsible for inaccessibility to healthcare systems.
- ▶ Improvement in quality of health services and strict regulation of untrained traditional birth attendants can minimise the health hazards.

Competing interests None.

Patient consent Obtained.

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