

Vaginally inserted herbs causing vesico-vaginal fistula and vaginal stenosis

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Abstract A 32-year-old woman developed a vesico-vaginal fistula and vaginal stenosis following insertion of herbs into her vagina by a traditional doctor to “melt” her uterine myomata. She underwent successful trans-abdominal repair of her fistula and passive dilatation of her vagina was recommended for the vaginal stenosis. The emerging importance of traditional treatments as a cause of vesico-vaginal fistula is highlighted. The role of quality improvement through research and strict regulation to maximise the benefits of traditional treatment and minimise complications is also emphasised.

Keywords Vagina · Herbs · Vesico-vaginal fistula

Introduction

Vesico-vaginal fistula is rare in developed countries, but remains a problem for women in developing countries. Obstetric trauma, the leading cause, still persists in developing countries, where obstetric care remains deficient and pregnancy- and childbirth-related injuries continue to plague women [1]. A patient with vesico-vaginal fistula resulting from vaginal insertion of herbs to “melt” uterine myomata is presented in this report to shed more light on the vexed issue of incontinence from vesico-vaginal fistula and the diversity of etiological factors.

Case presentation

A 38-year-old single but sexually active woman was diagnosed with multiple uterine fibroids in a private hospital in a major industrial city in southwest Nigeria, where she

presented with complaints of discomfort and feeling of a mass in her lower abdomen. She was otherwise healthy. Acting on her friends’ advice she was treated with herbal preparation inserted into her vagina by an herbalist in “in order to melt the fibroids”. The preparation was in the form of a thick, cream-colored paste digitally loaded into her vagina and left in situ for 2 weeks. The ingredients of the preparation were not disclosed to her, but she suspected them to consist mainly of leaves of a certain plant ground into a paste mixed with other agents unknown to her. About 2 weeks later, she noticed involuntary passage of urine from her vagina. There was no loss of fecal or flatus control. Her fibroids and the associated symptoms did not disappear. A nearby hospital diagnosed her with uterine fibroids and vesico-vaginal fistula. An open abdominal myomectomy was performed and an attempt was also made to repair her fistula via the vaginal route, which failed. Her abdominal wound healed nicely, but leakage of urine persisted. Bothered by the persistent leakage of urine and the associated offensive odour, she took a long holiday from her office and sought help in a tertiary hospital about 900 km from her home. During examination she was found to have leakage of urine through a stenosed vagina, which could admit only 3 cm of the examining finger. The fistula was beyond reach and could not be further evaluated. Under anaesthesia, urine was found to be leaking through the vagina, but the extensive vaginal stenosis did not permit further characterisation of the fistula. During extra-peritoneal trans-vesical repair, the fistula was located just proximal to the internal urethral meatus, with no ureteric involvement. The fistula measured about 2 cm along its largest diameter and was repaired in layers: the vagina first, then the bladder, using Vicryl 2/0 suture. A urethral catheter was placed, to be left in situ for 14 days. Post-operatively, she leaked urine slightly between days 7 and 17, and the duration of catheterisation was extended to 28 days, then the leakage stopped. Continence was achieved and maintained even at the 12-week follow-up visit. For treatment of her stenosed vagina, she was counselled on passive dilatation, but was lost to follow-up thereafter.

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Discussion

The use of local herbs for medicinal purposes is not new in Africa, but vaginal insertion to “melt” uterine fibroids is unusual. In the patient under review, the effect of the herbs on the uro-genital tissue suggested its severely corrosive nature. In the English language literature, mention of herbs with corrosive contents leading to the development of urogenital fistulae is rare. Basak and Bag described one such herb used in a 62-year-old Indian woman, who applied a pasty material over her prolapsed vagina and subsequently developed vesico-vaginal fistula [2]. Another case was described in the oil-rich Niger Delta region of Nigeria where a traditional doctor inserted herbs into the vagina of a young woman [3].

The high location of the fistula in our patient would suggest that the herbs were placed high in the vagina since they were intended to “melt” her uterine fibroids. However, up to 6 cm of the length of the distal vagina was ultimately affected, with scarring and stenosis in addition to ulceration into the bladder, which resulted in vesico-vaginal fistula. This high location of the fistula, together with the extensive tissue scarring, made trans-vaginal repair difficult and informed the choice of the trans-abdominal extra-peritoneal repair route. Although this route is infrequently chosen, fistula size and location as in this patient as well as concurrent intra-abdominal pathology and ureteric involvement could favour its choice. Singh et al. have reported impressive success rates with the use of the trans-abdominal route [4]. One important downside of the extra-peritoneal route used in this patient is the difficulty in graft interposition, which would have added integrity to the repair.

As in all cases of vesico-vaginal repair, urethral catheterisation is required to continuously drain the bladder, keep the repair site dry, and prevent retention of urine. There is no consensus on the optimal duration of catheterisation, but fistula surgeons use 14 days’ duration for primary repair and 21 days if there was bladder neck involvement or if urethral reconstruction was performed, or if post-operative leakage was experienced, as was the case in this patient [5]. The 28-day duration of catheterisation used in this patient was necessitated by her experience of some urinary leakage on days 7 to 15 post-surgery and by fears of a recurrence.

The vaginal stenosis with which the patient also presented is an often reported complication of vaginally inserted corrosives. Surgical management is frequently employed, but could be challenging. Gradual dilatation is also used for some cases of congenital stenosis and as prophylaxis for iatrogenic stenosis [6]. The option of vaginal dilatation was made in this patient to limit additional morbidity. This patient’s default from follow-up was a missed opportunity to assess the success of this method. A failure would have necessitated a vaginoplasty.

These cases of vesico-vaginal fistula following the utilisation of traditional treatments draw attention to the risks associated with such practices. However, traditional treatments have a long and diverse history of effectiveness and benefits, filling critical health access gaps, especially in under-resourced parts of the world. In order to harness these potential benefits, research and regulation are needed, with emphasis on improving quality and minimising complications.

Conflicts of interest None.

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