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Case Report

Intravesical Foreign Body and Vesicovaginal Fistula: A Rare Complication of a Neglected Pessary

M. H. T. Grody, P. Nyirjesy and A. Chatwani

Temple University School of Medicine, Philadelphia, Pennsylvania, USA

Abstract: A silicone Gellhorn pessary, 3 inches in diameter, neglected for several years in an elderly woman, eroded through the anterior vaginal wall, ultimately to lie entirely within the bladder. General anesthesia and bilateral deep full-length Schuchardt's incisions were required to remove it. A Latzko procedure was done at a later date to close the large vesicovaginal fistula; similar Schuhardt's incisions were again used.

Keywords: Pessary; Prolapse; Vesicovaginal fistula

Introduction

Pessaries are often used in the management of symptomatic genital prolapse in a patient of advanced age, in the presence of medical complications that preclude surgical intervention, or often, when the patient refuses to undergo surgery. Rare complications of a neglected pessary include vesicovaginal fistula [1–3], rectovaginal fistula [1,2], cervical entrapment [4] and pessary incarceration [5]. A vaginal pessary may come to lie entirely within the confines of an adjacent organ, such as the bladder. We present such a case with a large vesicovaginal fistula resulting from a neglected silicone Gellhorn pessary, in which the subsequent course required innovative management.

Correspondence and offprint requests to: Dr Marvin H. Terry Grody, Department of Obstetrics and Gynecology, Temple University Hospital, 3401 N. Broad Street, Philadelphia, PA, USA.

Case Report

A 98-year-old white multiparous patient presented with a complaint of continuous and involuntary loss of urine of several months' duration. She had had a uteropelvic prolapse corrected 18 years earlier by the placement of a large Gellhorn stem pessary. Initially the patient had periodic and frequent examinations, but then neglected to return for examination because of the absence of any symptoms. She had never used any hormone replacement therapy. Since the incontinence was first noticed, the patient had been seen by numerous gynecologists and urologists. Outpatient attempts at pessary removal were unsuccessful, as was an attempt to remove the pessary under anesthesia.

Examination at our institution revealed urine flowing through an extremely constricted vaginal introitus and vagina. The tip of the Gellhorn stem pessary was palpated with one finger. Rectal examination revealed a tiny uterus, now locked firmly in a well elevated position. Otherwise the patient was in excellent health, with full mental lucidity. Oral and intravaginal estrogen was initiated.

Six weeks later, under general anesthesia, bilateral deep full-length Schuchardt's incisions were made in the 4:30 and 7:30 o'clock positions. Then, with extreme difficulty, after hooking tenacula into the firm Gellhorn stem to assist in traction, applying copious lubrication, and after extensive manipulation, the mushroom base measuring 3″ in diameter, was removed. Examination revealed a 4 cm linear vesicovaginal fistula with edematous edges. Cystoscopy revealed ureteral orifices well removed from the edges of the fistula. The two Schuchardt's incisions were then closed.

Estrogen replacement was continued. Nine weeks after removal of the pessary the patient underwent

closure of the vesicovaginal fistula by a standard, albeit very extensive, Latzko procedure. The same two Schuchardt's incisions were created for adequate exposure. After the required mucosal denudation, the usual three closure layers were completed, using 0 polyglycolic sutures. One year following the surgery the patient remains continent.

Discussion

Pessaries have long been useful in the management of genital prolapse for a variety of reasons, principal among which are older age, the presence of medical complications that preclude surgical intervention, or the patient's refusal to undergo surgery.

Although rare, unusual complications of neglected pessary include vesicovaginal fistula [1–3], rectovaginal fistula [1,2], cervical entrapment [4] and pessary incarceration [5]. A search of the Medline database from 1966 to the present revealed only three other cases of vesicovaginal fistula secondary to a neglected pessary. In all the described cases the fistulae occurred in women who had had pessaries in place for a long time without having them removed and having the vaginal walls inspected for ulceration.

In the elderly hypoestrogenic patient who has not been examined for many years, such severe introital constriction can occur that the pessary cannot be removed. In such patients oral and topical estrogen can be used to increase the flexibility of the vaginal tissues, thereby to increase access to the pessary itself. However, even with hormone therapy and general anesthesia, an incarcerated pessary can remain a vexing problem. Schuchardt's incisions, equivalent to bilateral mediolateral episiotomies, were successfully used in this patient to obtain adequate room for pessary removal. In the other cases [1–3] of vesicovaginal fistula occurring following pessary use, the fistulae themselves were repaired via a transabdominal approach. However, with adequate repeat Schuchardt's incisions we were able to successfully close this patient's fistula transvaginally. Consideration was given to a possible abdominal approach in this patient, but it was felt that a minimum of two operations would be necessary, one for pessary removal and the other for fistula closure. We felt that a vaginal approach represented an equivalent chance of ultimate success while decreasing the morbidity and prolonged recuperative period which are intrinsic to two abdominal surgeries in a 98-year-old patient.

To avoid major complications of a pessary we recommend that the patient be made aware of the importance of frequent and periodic examination. The device should be removed at each visit and the vaginal epithelium inspected for evidence of deep ulceration. Consideration should be given to placing the postmenopausal patient on estrogen therapy to thicken the vaginal walls and theoretically decrease the risk of fistula formation.

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