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*Abstract Title:* **Genitourinary fistulas: Etiology, diagnostics, prevention**

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**Introduction & Objectives** The incidence of iatrogenic genitourinary fistula has no tendency to decrease, despite the existence of technical possibilities to improve the visualization of the operations area with the help of video assistance and even use of luminous ureteral stents. The occurrence of genitourinary fistula after surgery leads to significant deterioration in the quality of life (including sexual) and social adaptation (frequent change of clothes, unpleasant odor, maceration of the skin of genitals, the inability to fully engage in labor activity) of women. These circumstances determine the relevance of generalizations of literature and data obtained by us with the aim to identify the main reasons of occurrences, the principles of effective and accurate diagnosis, which should help in the surgical treatment of genitourinary fistulas for the earliest return of this category of women to a normal quality of life.

**Material & Methods** The records and details of genitourinary fistulas treated between 2008 and 2015 in the 4<sup>th</sup> city clinic of Minsk were analyzed. We treated 27 women (age 22-82) with verified genitourinary fistulas.

**Results** fistulas were more frequent appear in patients aged 45-55 years (17; 63%). In most cases, they are able-bodied and sexually active women. The main reasons for the formation of genitourinary fistulas were gynecological surgeries. Surgical interventions with laparotomy access have led to the development of fistulas in 20 women - 74.1% of cases, and laparoscopic operations - in 7 women - 25.9% of cases. After laparotomy more recently formed vesicovaginal fistula (13; 65%), after laparoscopic - ureterovaginal (5; 71,4%). The share of vesicovaginal fistulas had 15 (55.5%) cases, and the share of ureterovaginal fistula -12 (45.5%). Only in 9 (33.4%) of the 27 patients we have information about urine culture. Three patients revealed growth of colonies of E.coli, two - E. faecalis, one patient - Staphylococcus epidermidis, one patient - Proteus mirabilis, two women had negative growth. The most common method of verification of vesicovaginal fistula was cystoscopy and vagina examination, and to diagnose ureteral-vaginal fistula using excretory urography, URS with retrograde ureteropyelography, also we use CT or MRI of pelvic area in special cases. Coincidence diagnosis before and after the operation was in 100% cases.

**Conclusions** 1. It is necessary, in all patients whom planned plastic of genitourinary fistula, to undergo antibiotic therapy according to the presence of microflora and its sensitivity to antibiotics, until negative urine culture in the pre-hospital stage.

2. Surgical interventions with laparotomy access have led to the development of vesicovaginal fistulas, and laparoscopic access - for ureteral-vaginal fistulas formation.
3. For diagnosis it is enough to use plane and excretory urography; cystoscopy (URS) with retrograde ureteropyelography, vagina examination, CT or MRI of pelvic area in special cases.