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Sexual Function Before and After Vesicovaginal Fistula Repair

Rachel Pope, MD, MPH,[1] Prakash Ganesh, MD, MPH,[2] Chisomo Chalamanda,[3] William Nundwe,[3] and Jeffrey Wilkinson, MD[1]

ABSTRACT

Introduction: Women with vesicovaginal fistulas often experience a disruption in their normal lives, including sexual relationships, because of urinary incontinence.

Aim: Although surgery repairs the urinary leakage, it is not known how surgery might affect sexual function positively or negatively.

Methods: 119 women were enrolled before surgery and interviewed including a revised Female Sexual Distress Scale (FSDS-R) score and examined for vaginal length, caliber, and pelvic floor strength.

Main Outcome Measures: Approximately one third of women return to normal sexual function after repair, although a minority experience de novo dysfunction.

Results: 115 women completed follow-up 6 to 12 months after surgery. Approximately one third (35.6%, n = 41) stated that intercourse had returned to the way it was before a fistula. Forty-four women (40%) report sexual problems after the fistula developed; 15% due to incontinence and 23.5% due to pain. Fourteen women (12.2%) stated that they experienced problems with intercourse since surgery; 50% due to incontinence during intercourse and 50% due to pain. Nineteen of the participants (16.5%) scored in the range of dysfunction as assessed by the FSDS-R tool after surgery. Fibrosis did not significantly change and was not found to be associated with sexual function. Vaginal length was found to decrease on average by 5 mm. Of the variables examined, the factors statistically significantly associated with dysfunction included a larger-size fistula as determined by the Goh classification (> 3 cm diameter) and decreased vaginal caliber. FSDS-R scores drastically decreased from before to after surgery and the reason for problems with intercourse changed from leaking urine before surgery to lack of partner and concern for HIV infection.

Clinical Implications: Women with large fistulas and decreased vaginal calibers are at high risk for sexual dysfunction and should be counseled appropriately preoperatively and offered surgical and medical interventions.

Strengths & Limitations: Physical parameters were combined with qualitative interviews and FSDS-R scores to contextualize sexual health before and after surgery. Limitation is the brief follow-up of 6-12 months after surgery as many women were still abstaining from sexual activity.

Conclusion: Sexual dysfunction is a complex issue for women with obstetric fistulas; although many women do not continue to experience problems, several need ongoing counseling and treatment. **Pope R, Ganesh P, Chalamanda C, et al. Sexual Function Before and After Vesicovaginal Fistula Repair. J Sex Med 2018;XX:XXX−XXX.**

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Key Words: Obstetric Fistula; Vesicovaginal Fistula; Sexual Function; Sexual Dysfunction

INTRODUCTION

Urogenital disorders with and without surgical intervention have been found to be closely linked to sexual dysfunction.[1] Vesicovaginal fistulas are no exception. Although continence may have been restored, the soft tissue of the pelvic floor may be contracted and scarred. The lack of compliance of the pelvic tissue could be from the initial obstructed labor and pelvic trauma, and chronic dermal irritation from urine can result in profound dermatitis and fibrosis. Furthermore, a report from a conference held on meeting the needs of women with "fistula

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[1]Baylor College of Medicine, Department of Obstetrics and Gynecology, Division of Global Women's Health, Houston, TX, USA;

[2]International Training and Education Center for Health (I-TECH), University of Washington, Seattle, WA, USA;

[3]Fistula Care Center, Lilongwe, Malawi

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deemed incurable," noted that women who are unable to resume sexual function may not consider their condition cured.[2]

Women with obstetric fistulas tend to experience many physical and emotional stressors that could all contribute to relationships and sexual function. Many lose partners and spouses due to incontinence or to the perception of or experience of infertility. Many women are inhibited from interacting socially, are accused of being cursed, and experience socioeconomic losses.[3] The hope for many women is that surgery will return their lives back to "normal" in all areas.

Fistula surgeons have cited patients returning after successful surgical closure of a fistula requesting to have the surgery reversed.[4] Before repair, these patients were having sexual intercourse with their bladder as a replacement for the vagina. At the time of surgery, many women are found to have varying severity of vaginal fibrosis, likely from the ischemic process of the obstructed labor. The closure of the fistula in the setting of marked vaginal stenosis or complete obliteration may result in a subsequent inability for them to continue sexual intercourse. One study has been published on the subject but did not include any physical characteristics or factors associated with dysfunction.[5] In Malawi, as in many other sub-Saharan African countries, sexual relations are associated with marital, social, and economic stability and therefore are paramount concerns for patients who have been divorced or otherwise shunned by their communities because of a fistula.

Pelvic rest is recommended after surgery for 6 weeks to 6 months; however, the optimal time required for adequate healing before sexual relations is unknown. Some patients described difficulty in abstaining from sexual intercourse due to their husbands' demands, and some experience rape.[6] Others describe never wanting to engage in intercourse or pregnancy again for fear of developing another fistula.[3,7] Other studies have shown that future childbearing and economic security are matters of concern to women after repair.[8]

Therefore, when providing vesicovaginal fistula repair services, it is imperative to address factors associated with sexual function and this should be considered part of comprehensive fistula care. Although several articles on vesicovaginal fistula repair mention sexual function as a concern for patients as a residual problem, no literature currently has focused on the objective changes after surgery or the factors that contribute to new-onset dysfunction.[5,9–11] This study is designed to enhance the understanding of sexual function in women with obstetric fistulas and identify factors that lead to dysfunction.

MATERIALS AND METHODS

The primary objective of this study is to document the sexual function of women with vesicovaginal fistulas before vaginal surgery compared with 6 to 12 months after surgery and to identify factors contributing to dysfunction. Sexual function is assessed by the revised Female Sexual Distress Scale (FSDS-R). The FSDS-R is a validated tool of 13 questions aimed at capturing specific dysfunction symptoms.[12] The primary outcome is the number of women with fistulas with sexual dysfunction at baseline. The secondary outcome of interest is the number of women with fistulas without sexual dysfunction at baseline, who develop dysfunction after surgery.

We hypothesize that women with fistulas have sexual dysfunction before surgery for emotional and social reasons:

1. Women will largely experience sexual dysfunction before fistula surgery because of partner abandonment and embarrassment with incontinence.
2. Patients will expect surgery to restore sexual function and, by extension, relationships.

We hypothesize that women who develop de novo sexual function after surgery, will be primarily due to physical reasons. Specifically, women with fibrosis noted at the time of surgery will be those with new-onset sexual dysfunction after surgery because there will be less normal vaginal tissue after surgery. These individuals will have worsened sexual function 6 to 12 months after surgery. Those without fibrosis will have improved function 6 to 12 months after surgery.

This was a prospective cohort study with mixed methodology, including qualitative interviews and quantitative measurements to contextualize the factors associated with sexual function. Ethical approval was obtained from the Malawi National Health Sciences Research Committee and the Baylor College of Medicine institutional review board. Women who presented for vesicovaginal fistula surgery at the Fistula Care Centre were voluntary participants in this study. Informed consent was obtained, and participants provided oral and written consent to participate. Patients not eligible for the study were those who had previously undergone surgery for fistula repair, those scheduled for abdominal repair, and those aged younger than 18 years. After providing consent, participants were interviewed by a research nurse using a structured questionnaire about overall sexual behavior and history of sexual problems before developing a fistula, as well as since developing a fistula. Questions were either dichotomous or categorical with an option to elaborate or offer "other" answers when appropriate. The interview also included the FSDS-R, which was translated into Chichewa with consultation from Malawian nurses and social scientists, all fluent in Chichewa. It was administered during the interview orally due to varying levels of literacy of participants. All questions were recorded on a hard-copy form and later transcribed and entered into a RedCap database.[13]

At the time of surgery, before initiation of anesthesia, vaginal measurements were obtained including vaginal length, vaginal caliber as determined by a silicone dilator, presence of fibrosis or atrophy, and ability to relax and flex the pelvic floor. All participants underwent the same standard of care for vesicovaginal fistula repair using Vicryl polyglactin suture and tension-free closure of the bladder and vagina. Participants, just as all

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