

4 PREOPERATIVE PREPARATION

Is the patient fit for operation?

In Uganda, we find that most patients are in good general condition and ready for operation after a day's preparation. In Ethiopia, more patients are weak and malnourished, and a few have contractures. Findings will vary from country to country. It is always advisable to improve the patient's general condition by improved nutrition, iron and vitamin supplements, de-worming, and treatment of malaria. Contractures should be treated before surgery if possible.

Haemoglobin should be estimated. It should ideally be above 10 g/100 mL, but lower levels can be accepted for simple cases, where blood loss should be minimal. For difficult cases, blood should be taken for grouping. Transfusion is occasionally advisable.

It is not surprising that a recent small study has confirmed that many patients suffer from severe depression. Sympathetic handling is called for, but no amount of 'counselling' will improve a patient's mental state until she has been cured of constant incontinence.

Neurological damage and physiotherapy

Neurological damage is a marker for a severe injury. At the extreme, the patient may be unable to walk immediately after delivery due to ischaemia to the lumbar–sacral plexus (Figure 4.1). Immobility may lead to pressure sores, compounded by the presence of saddle anaesthesia.

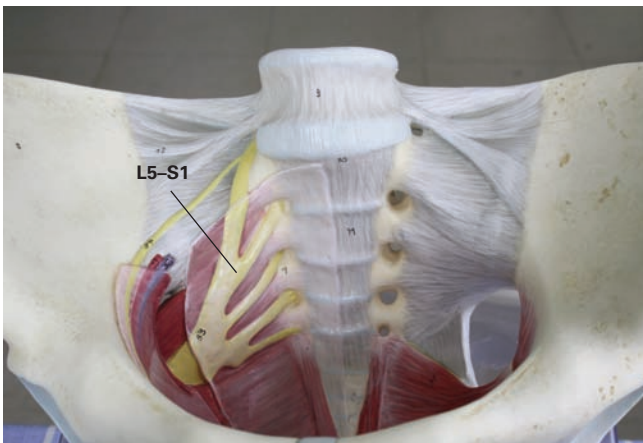


Figure 4.1 The L5–S1 roots are particularly at risk from ischaemia at the pelvic inlet.



Figure 4.2 (a) This patient could only crawl 2 weeks post delivery. She has both a vesico-vaginal fistula and a recto-vaginal fistula. (b) One week later, she could just walk with support, but had bilateral foot drop. At 6 months, she just had mild unilateral foot drop. Both fistulae were closed, but stress incontinence remained a problem.

With good nursing care, the majority of patients improve (Figure 4.2). With good nutrition and active and passive movements of all joints, motor power and sensory loss will improve, although foot drop (due to damage to the L5 root) will be the last to recover (if it does at all). The provision of splints prevents contractures in plantar flexion. However, they should not be a substitute for putting all affected joints through a full range of movement several times daily. Residual foot drop, especially if a fixed plantar flexion has been allowed to develop, is a serious disability that will impair the patient's ability in daily activities.

It is easy to understand how, in the absence of any medical help, contractures form, especially if the patient is rejected and lies in one position for days on end, hoping that the incontinence will stop (Figure 4.3). This is particularly prone to occur in Ethiopian society, where many of the patients are child brides in remote areas. About 2% of patients presenting at the Addis Ababa Fistula Hospital have severe contractures. These require months of passive stretching exercises before they are fit for repair. A dedicated physiotherapy department enables severe contractures to be considerably improved in time (Figure 4.4).

Explanation

Clearly, the patient must be prepared for what is going to happen in the operating theatre and must give her consent. She must be informed about the length of postoperative stay, the duration the catheter will be kept in and the restrictions on her activities. She and her attendant must understand that they should not rush off home immediately the catheter is removed. Those who operate on difficult cases



Figure 4.3 (a) This was the only patient in over 1000 seen in Uganda who had significant contractures. She had lived in a sack for 6 months after her stillbirth! There was no time to correct the contractures, so her fistula was repaired. (b) She returned cured of her incontinence, bearing a chicken in thanks, but still walking on her knees. In spite of careful instruction, she had been unable to find anyone to help her with regular stretching exercises after her operation.



would be wise to warn the patient of the limitations of surgery in achieving a cure, including the risk of stress incontinence, so that expectations are not raised too high.

Bowel preparation

It is best to have the rectum empty during the operation in case there is any leakage though the anus. In ideal circumstances, the patient would have an enema the day before, but in reality enemas are forgotten or given at the last minute, often leading to contamination during the operation. It is much better to give no enema at all and simply to be sure that the patient has been asked to open her bowels before coming to theatre.



Figure 4.4 The Addis Ababa Fistula Hospital has a well-equipped physiotherapy department. Months of work must be done to slowly improve contractures.

An enema does need to be given the evening before operation in cases of recto-vaginal fistula or sphincter repair.

In the uncommon event of troublesome anal leakage, we clean up and insert a temporary anal purse-string suture, and carry on operating.

Hydration

Left to her own devices, the patient will come to theatre dehydrated, as she will be trying to reduce the amount of wetness. This is a bad thing, for a number of reasons:

- She may be hypotensive under a spinal anaesthetic.
- It increases the difficulty in identifying the ureteric orifices.
- The urine output will be poor after the operation, predisposing to catheter blockage. More intravenous fluids will be required during and after the operation. They are expensive.



Figure 4.5 If the patient has been drinking sufficiently, urine should be seen dripping when she stands with her legs apart. (Photograph courtesy of Kees Waaldijk.)

Therefore, as soon as the decision is made to operate, ask the patient to start drinking plenty of mixed fluids, only stopping 4 hours before the operation. If she has been drinking sufficiently, urine should drip when she stands with her legs apart (Figure 4.5). Set up an intravenous infusion of saline before she goes to theatre,

Be aware of the very rare but serious condition of hyponatraemia (see Chapter 11).