10.5005/jp-journals-10032-1058

CASE REPORT

Youssef's Syndrome

[1]Prakash Kumar Nath, [2]Mamata Samal, [3]Kumudini Pradhan, [4]Chintamani Mohanta, [5]Sanjaya Mahapatra

ABSTRACT

Vesicouterine fistula (Youssef's syndrome), a rare complication of cesarean section is presented. A 35-year-old female had vesicouterine fistula with symptoms of apparent amenorrhea, cyclic hematuria and meconuria following cesarean section. The patient was treated by abdominal hysterectomy and the fistula tract was repaired.

Keywords: Vesicouterine fistula, Hematuria, Meconuria.

How to cite this article: Nath PK, Samal M, Pradhan K, Mohanta C, Mahapatra S. Youssef's Syndrome. J South Asian Feder Menopause Soc 2014;2(2):113-114.

Source of support: Nil

Conflict of interest: None

INTRODUCTION

The most common cause of vesicouterine fistula is obstructed labor in developing countries. Next to it cesarean section is the culprict. The classic triad of vaginal urinary leakage, cyclical hematuria and amenorrhea is known as Youssef's syndrome which is vesicouterine fistula.

CASE REPORT

Mrs XYZ, P_2L_2, 35-year, hindu female from Jharsuguda came to VSS MCH, BURLA with chief complain of cyclic bleeding per urethra for last 2 months. Patient was apparently all right 2 months back, to start with she developed pain abdomen with cyclic bleeding per urethra and leaking of urine per vagina. Her first pregnancy was ended by LSCS with live female child 5 years back due to obstructed labor. 6-month back, she undergone repeated LSCS with live female child. Her pulse was 84/min, BP 120/82 mm Hg, B/L vesicular breath sound with no added sound, S_1,S_2 normal with no murmur. On per abdomen soft, scar healthy. Per speculum, cervix was healthy. On per vaginal examination anterior fornix was obliterated as if the base of the bladder is fixed to the supravaginal portion of the cervix, rest of the fornices were free, uterus was midposed, just bulky and mobility slightly restricted. A rent on the posterosuperior wall of the bladder communicating to uterine cavity seen in cystoscopy. On hysteroscopy, a rent on the anterior wall of the uterus seen. Clinical impression of uterovesical fistula was made. Decision was made to explore the patient for fistula repair transabdominally. There was fistulous tract between dome of bladder and isthmic region of uterus of around 2 cm in length, rest of bladder was advanced into isthmic region of uterus with adhesions. Abdominal hysterectomy was done, followed by excision of fistulous tract, bladder closure done in 2 layers, with 2-0 polyglactin. Catheter was kept for 2 weeks. Urine was sent for culture and sensitivity weekly, which showed no

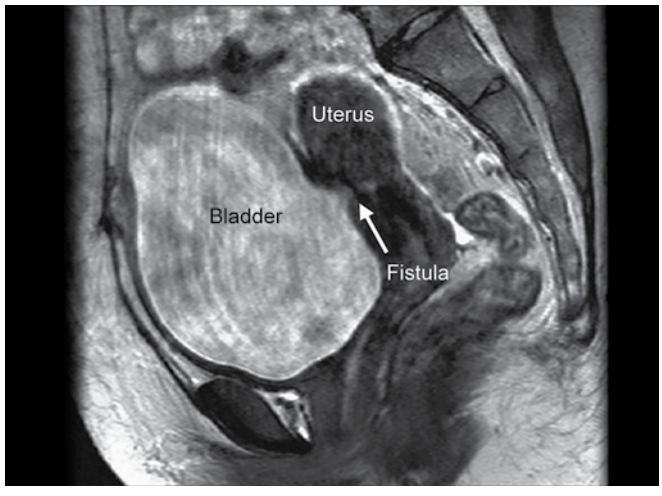

Fig. 1: Vesicouterine fistula

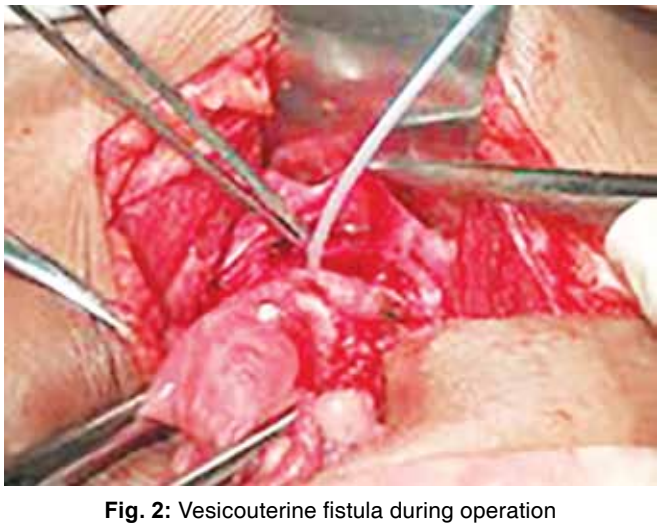

Fig. 2: Vesicouterine fistula during operation

[1,2]Postgraduate Student, [3]Associate Professor, [4]Assistant Professor, [5]Senior Resident

[1-4]Department of Obstetrics and Gynecology, VSS Medical College, Sambalpur, Odisha, India

Corresponding Author: Prakash Kumar Nath, Postgraduate Student, Department of Obstetrics and Gynecology, VSS Medical College, Sambalpur, Odisha, India, Phone: 9861305523, e-mail: drprakashnath@gmail.com

growth. Catheter was removed on day 14 after bladder drill. The patient could void subsequently with residual urine of < 30 ml detected on ultrasonography. The patient was discharged with follow-up advice.

DISCUSSION

Most common form of urogenital fistula is vesicovaginal fistula. In developing countries most common etiology is obstructed labor though vesicouterine fistula are formed after prior cesarean section. Prior history of cesarean section and patient presenting with clear watery discharge per vaginum, cyclical hematuria and amenorrhea should point to urogenital fistula, mostly vesicouterine fistula with no fistula visualized on per vaginal examination or with great difficulty if upper cervix also involved.[1] Thorough clinical examination, investigation like; ultrasonography pelvis, sonohysterosalpingography, color Doppler, retrograde cystourethrography (Fig. 1). Intravenous pyelography aid in diagnosis of type of fistula. Cystourethroscopy is the most definitive investigation with hysteroscopy if clinical suspicion of uterovesical fistula is made.[2] Fistulas detected within 48 hours should be repaired early, while fistulas reporting later than this should be repaired after 1½ to 2 months, allowing tissues to heal properly and for edema to get resolved with scar formation. Fistula repair should be approached transabdominally in cases of large fistula; fistula located high on posterior bladder wall, involving ureters is concurrent intraabdominal pathology. Omental flaps interposition aid in successful fistula repair (Fig. 2). After fistula repair, integrity of bladder repair may be tested with 200 ml of fluid colored with methylene blue or indigo carmine. Postoperatively bladder can be drained for as long as 3 weeks. The need for cystogram before discontinuing drainage is unproven.[3]

REFERENCES

1. Porcaro AB, Zicari M, Zeechini Antoniolli S, et al. Vesicouterine fistulas following cesarean section: report on a case, review and update of the literature. Int Urol Nephrol 2002:34(3): 335-344.
2. Yip SK, Leung TY. Vesicouterine fistula: an updated review. Int Urogynecol J 1998;9(5):252-256.
3. Youssef AF. Menouria following lower segment cesarean section: A syndrome. Am J Obstet Gynecol 1957;73(4):759-765.