

# Chapter 6

## Post-operative Complications and Challenges

### Blocked catheters

Blocked catheters, as already mentioned, can be a disaster for patients following fistula surgery. If the catheter has blocked and gone unnoticed, the bladder will fill up, stretching the repair site. Eventually urine will escape through the wound ruining the repair or bypassing the catheter. The first signs of a blocked catheter may be the patient complaining of abdominal pain from a full bladder.

To check whether a catheter is draining, first raise the catheter above the level of the bladder and see whether urine runs back down the tube back into the bladder. Take note of any kinks, blood clots, tissue debris or pus in the catheter that may be causing a blockage.

If the catheter is not draining, it may need to be flushed. To do this a sterile 60 or 100 ml catheter tipped syringe is needed with a sterile receiver (kidney dish) and some normal saline. It is useful to have a few sterile packs containing a receiver and syringe ready for use if



Figure 62 Checking if catheter is blocked

and when required. Using sterile equipment will reduce the chance of introducing infection into the bladder during irrigation.

A catheter flush involves gently pushing 25 ml of saline through the urinary catheter to dislodge any clots or debris that may be blocking the catheter, then reattaching the catheter tubing and allowing it to drain freely. There can be a temptation to pull back on the syringe during irrigation, but this should be avoided, as it may inadvertently cause injury to the repair site in the bladder wall if the catheter balloon is sitting near the wound.



Figure 63 Carrying out a catheter flush

If the catheter does not unblock after flushing with saline, then it needs to be replaced with a new Foley catheter. If blood clots are the cause of the blockage, a larger size of catheter will need to be passed when it is replaced – sizes 18F or 20F are ideal. All nurses should have training to be able to pass a urinary catheter using an aseptic technique.

### **Bloody urine/clots**

If the patient is not drinking enough fluid, the urine in the catheter will be dark in colour and may have blood and clots in the tubing. Clots

and debris in the catheter can cause the catheter to block. Make sure the patient drinks more and that they have an attendant providing them with ample fluids. The patients should be encouraged to drink until the urine in the tubing becomes clear.



Figure 64 Bloody urine

Patients who have had their bladder opened to reach the fistula or have undergone a ureteric re-implantation operation may have blood in their urine for a few days. This can be alarming for patients, but if they are drinking plenty, they can be reassured that it will settle in a few days.

Most patients will need to be reminded daily to drink plenty and make sure their urine is clear in colour. It is helpful to encourage the attendant to assist with this.

### **Infection**

Infection can occur in the post-operative period despite the use of prophylactic antibiotics. If not recognised early, sepsis can develop and is the most common cause of a failed repair.

Infection from the vagina produces pyrexia, increased discharge, secondary bleeding and a bad odour. You should always check there is no swab retained in the vagina. Daily temperature recordings will help detect early signs of infection.

High fluid intake reduces the risk of the patient developing a urinary tract infection. Patients who develop severe infection should be treated with IV antibiotics. Ampicillin 1 g once daily or ciprofloxacin 400 mg 12-hourly for 3 days IV should be started and is usually sufficient to treat the infection. Simple urinary tract infection or genital infection can be treated with oral antibiotics. Where facilities are available, a wound swab or urine sample should be sent for culture and sensitivity testing. However, treatment must not be delayed by waiting for the results to come back before medication is started.

Wound infections may also occur in patients who have had an abdominal repair or a flap such as the Singapore or Martius. If the wound becomes infected, daily wound dressings and antibiotic treatment will be necessary.

Patients who have had a 3rd or 4th degree tear repair may also need antibiotics if their wound becomes infected. As stated previously they should be advised to clean their wound with water every time they open their bowels and then to pat the skin dry.

## **Bleeding**

If any bleeding occurs within the immediate post-operative period, the patient must be taken back to theatre to determine the source of the bleeding. Most patients will have their bleeding arrested with more packs inserted into the vagina. Where the bleeding is arterial, this can only be stopped surgically through a further operation.

Bleeding is less common in the second week post-surgery and is almost always caused by infection. An area of the wound may become infected with slough breaking off leaving an exposed area that can be the cause of bleeding. Most bleeding can be stopped by 'packing' the area, but on a few occasions the patient may need to return to theatre for exploration and surgical intervention to arrest the bleeding. Late bleeding secondary to infection should also be treated with antibiotics (oral metronidazole and cephalexin or amoxicillin).

If a patient has had significant bleeding, they may need a blood transfusion if available at the fistula treatment centre. Check the results of the patient's pre-operative Hb level which can help determine whether they need blood. If their pre-operative Hb was low and they have been bleeding, it is advisable to repeat the Hb and do a cross match if not already undertaken and give a transfusion of blood. If the Hb is within the normal range, they can have oral iron and folic acid (fefa) for 4 weeks.

## **Spinal headache**

A few patients will suffer from a headache following spinal anaesthesia. They should be advised to lie flat on the bed and not get up for a few days until the headache resolves. Paracetamol can be given for pain relief, but a few may need stronger analgesia such as intramuscular diclofenac or tramadol. They should also be encouraged to drink more water. Some may find the caffeine in a cup of tea helps reduce the headache.

## **Vomiting post-anaesthetic/ileus**

A few patients may experience nausea and vomiting after a spinal or general anaesthetic. Those who have required ketamine may take longer to recover from their anaesthetic and will need to be nursed in bed until they are able to eat and drink and are ready to mobilise. An anti-emetic such as metoclopramide or ondansetron can be administered, if available, to relieve their symptoms. IV fluids are also required until the patient is able to drink enough to keep the urine clear.

A small number of patients may suffer from paralytic ileus following an abdominal approach during surgery. If the patient continues to vomit, there are no bowel sounds and the abdomen becomes distended, a naso-gastric tube should be passed to empty the stomach and give the patient symptomatic relief. They will also need to remain 'nil by mouth' and have IV fluids running until bowel sounds are present, after which the patient can start drinking.

## **Patient becomes wet**

If the patient becomes wet within the first few days after surgery, this is usually a bad sign that suggests the repair has failed or they have a second fistula that has been missed on examination. There is usually little that can be done at this stage other than to keep the catheter in, in the hope that healing might occur. The patient will need to be counselled that further surgery is needed, and they will need to return for more treatment in the future.

A late leak, in the second week or later is usually due to infection or a blocked catheter. In these cases, the fistula repair site should have a good blood supply and patients are likely to heal if the catheter is kept in for longer. The patient will need to be reassured that staying in hospital for an extra few weeks with the catheter in could help to get them dry.

*NURSING CARE FOR WOMEN WITH CHILDBIRTH INJURIES*

Nursing these patients prone can help promote healing, as the wound at the base of the bladder will be uppermost with the catheter tip below (sump drainage). This involves keeping the patient in bed, lying



Figure 65 Patient being nursed prone

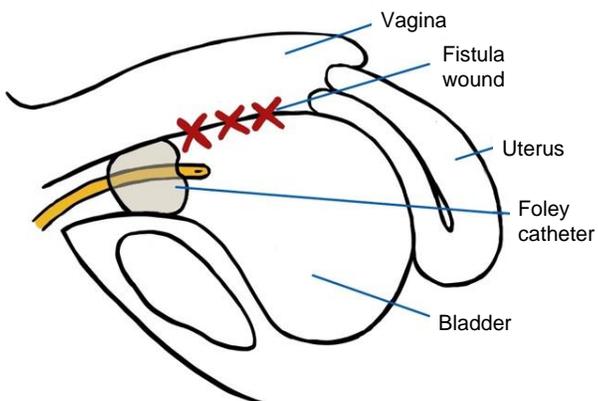


Figure 66 Sump drainage, (repair site uppermost when patient lying on their front)

and sleeping face down, only getting out of bed if they need to go to the toilet to empty their bowel.

### **Counselling women who have failed repairs**

Sadly, a few fistula repairs will not be successful following surgery even with good nursing care. These women will need counselling by the surgical and nursing staff, and must be encouraged not to give up hope of being cured. They need to wait at least 3 months, and preferably 6, after the initial surgery before a repeat attempt should be considered. This will allow healing of the tissues and offer the best chance of success from subsequent operations.

It is very distressing for both patients and staff when a repair has failed and the patient may feel she is the only one who is still wet, when her fellow patients appear to be dry. It is beneficial to introduce the women to patients who have returned for further surgery after experiencing a failed repair first-time round. Knowing all is not lost at this point is helpful to the women who have already been living a life of despair being wet from a fistula and may also have borrowed money to get to the hospital.

These women will need a lot of care and empathy to support them through the difficult period of coming to terms with going home continuing to experience the incontinence for which they initially attended. Some of them will go back home with a residual fistula smaller than the one they arrived with, so their incontinence may be less. They need to be advised when they can re-attend for surgery.



Figure 67 Counselling a woman with a failed repair

A small number of patients will have their fistula successfully repaired, but continue to leak urine from stress incontinence. This is due to the tissue and nerve damage of the urethra, which controls the body's ability to maintain continence. Such patients will benefit from careful counselling, so that they do not lose hope of becoming dry. They should be advised that additional operations may be necessary to help address their problem.