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A plea for recognising all causes of gynaecological fistulae

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Ten years ago, Lewis Wall (*Lancet* 2006;368;1201–9) aptly described the fistulae literature as one that 'consists mainly of anecdotes, case series (some quite large), and personal experiences reported by dedicated surgeons who have labored in remote corners of the world while facing enormous clinical challenges with scanty or absent resources at their disposal'. Today, reliable survey instruments to establish even the basic prevalence of gynaecological fistulae are still lacking (Cowgill et al. *BMC Pregnancy Childbirth* 2015;26:193). Chen et al. demonstrates that it is possible to start overcoming the usual feasibility, logistical, and resource issues that impede solid scientific method for the epidemiologic study of fistulae. They use a clever research design to conduct a tightly scientific study. Their new instrument, while admittedly not perfect, offers a solid estimate of true prevalence in at least one setting.

Fistulae identification is not simple, partly because of the variety of ways women are injured. The most common form of gynaecological fistulae are obstetric fistulae from obstructed vaginal delivery. But fistulae of underlying iatrogenic causes, for example on caesarean delivery or hysterectomy at caesarean, must also be recognised. Surgeons in under-resourced countries with little opportunity for specialty education and supervised experience, may inadvertently cause more iatrogenic fistulae (Onsrud et al. *Int J Gynecol Obstet* 2011;114:10–4). Separately, while far more rare than obstetric or iatrogenic fistulae, rape with extreme violence also causes fistulae, including rape with a foreign object. Epidemiologic screening surveys will fail these women if survey questions relate only to childbirth. It sends an incomplete message.

We need survey questions that take into account the full spectrum of fistulae causes, including violence or maybe even the slip of the hand by an exhausted and under-prepared surgeon. Chen et al. used a simple phrase to identify fistulae related to birth: 'closeness in date between an episode of childbirth and date of fistulae symptoms'. Can we add in like manner: 'closeness in date between an episode of rape and date of fistulae symptoms' or '... an episode of surgery and date of fistulae symptoms?' These are factual questions. And tragically, there are the areas of the world (e.g. Democratic Republic of Congo) where all three forms of the question would be applicable to the population (Mukwege & Nangini. *PloS Med* 2009;6;e1000204).

Fluctuation of fistulae prevalence from rape with extreme violence logically goes with outbreaks of war where conflict-rape is a terrorising weapon. But fluctuation of obstetric-related fistulae or iatrogenic fistulae is also logically based on socio-political outbreaks, such as war, where collapse of the infrastructure is so complete that women must deliver their babies in dangerous settings. Nevertheless, we must also recognise that all forms of fistulae occur in all economic and political environments. We do not know how often. We do not know very much of the essential information needed. We must applaud those such as Chen et al. who are working to address the enormity of that neglect.

Disclosure of interests

None declared. Completed disclosure of interests form available to view online as supporting information ■