Service Specification

No. | E10e | 4
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Service | Complex Gynaecology Services – Management of lower urinary tract fistulae and urethral diverticula
Commissioner Lead | Jacquie Kemp
Provider Lead | 
Period | 12 Months
Date of Review | 

1. Population Needs

1.1 National/local context and evidence base

- In this document the term ‘lower urinary tract fistula’ is taken to include any fistulous tract involving the bladder or urethra and the genital and/or gastrointestinal tracts and peritoneal and/or cutaneous surfaces. Lower urinary tract fistulae in the UK are seen in a number of situations, but are most commonly iatrogenic, and occur following by pelvic surgery (68%) or radiotherapy (10%).[1] Hysterectomy is the most commonly associated surgical procedure (50% of all cases, 72% of surgical cases),[1] and the risk varies between approximately 1 in 4000 for vaginal hysterectomy for prolapse and 1 in 100 for radical hysterectomy for cervix cancer.[2] Approximately 120 cases undergo surgical treatment within the NHS in England annually,[3] and hence they fall within the definition of specialised services (SSNDS no.4).
Despite clearly falling within specialised services national definitions set (SSNDS), and professional support of the concept,[4-6] there has not previously been national recognition of specialised services for lower urinary tract fistulae or diverticula. As a result current patterns of care are inconsistent, with the majority of cases being managed in units undertaking very small numbers of cases (one procedure in 10 years) and a minority being undertaken in units of modest activity (only three consultant teams currently undertake more than 3 procedures per year).[3] Approximately 20-25% of the national workload is undertaken in a single unit.[1]

The arguments for centralisation of services for fistula management are overwhelming and data indicates that probably only 3 centres are required in England to manage lower urinary fistulae. Surgical expertise and experience of the required range of surgical options is limited. Additional expertise from coloproctology and plastic surgery is essential to a comprehensive service, as are experienced nursing, physiotherapy, psychology, and patient support.

As indicated above, a majority of cases are currently managed in units undertaking very small numbers of cases (one procedure in 10 years). Over the last 10 years 281 consultant teams have managed only a single case each; these are primarily in the main specialty of Urology.[3] It is likely that these individuals look on fistula management as being sufficiently close to core Urology as not to require specific skills or workload.

It is clearly recognised that there is a need to move away from the current service model of commissioning small volume activity from multiple providers to implement a process of designation of providers who complete a minimum of 6 cases per year. This is likely to lead to the designation of 3 providers nationally. During the first year of implementation of this specification, local commissioning teams will be asked to map and report on providers and activity levels in their local areas and advise the Clinical Reference Group (CRG) on risks that will need to be managed during this transitional year and the processes that will be put in place to manage them, with a view to complete a designation process by March 2014.

2. Scope

2.1 Aims and objectives of service

The primary aims are:

- To provide a safe and effective care pathway for women with fistulae and diverticula
- To provide social, economic and psychological benefits for women requiring the
service
- To provide continuity of care through the whole care pathway encompassing other specialised services included within the pathway

2.2 Service description/care pathway

Procedures required
(Those in italic text are relevant to both fistulae and diverticula)

Investigative:
- **Endoscopy:** Cystourethroscopy (M45.1); (ureteroscopy (M30.4)); sigmoidoscopy (H25.1, H28.1); colonoscopy (H18.1)
- **Functional assessment:** urodynamics (M47.4), ano-rectal manometry (H46.3), nerve conduction studies (A84.3)
- **Imaging:** CT/IVU (U37.2), MRI (U085, U09.3), ultrasound (Q55.5), retrograde pyelography (M30.1)

Initial drainage procedures:
- Urethral or suprapubic catheterisation of bladder (M47.8, M38.2)
- Retrograde ureteric stenting (M27.4), nephrostomy (M13.6), antegrade ureteric stenting (M33.4)

Repair surgery:
- Vaginal repair of vesicovaginal fistula (+/- interposition) (P25.1)
- **Vaginal repair of urethrovaginal fistula (+/- interposition) (P25.2; M73.3)**
- **Urethral reconstruction (+/- interposition) (M73.4)**
- Colpocleisis (+/- interposition) (M18.1, M18.2)
- Abdominal transvesical repair of vesicovaginal fistula (P25.1)
- Abdominal transperitoneal repair of vesicovaginal fistula (+/- interposition) (P25.1)
- Ureteric re-implantation or repair (M21.1-M21.9)
- Urinary diversion (ileal conduit or continent diversion) (M19.1, M19.8)
Multidisciplinary Team membership:
- Urogynaecologist or Urologist with training & expertise in fistula management
- Urogynaecology (if urologist above)
- Urology (if urogynaecologist above)
- Coloproctology
- Nursing
- Physiotherapy
- Access to:
  - Nutrition (especially where bowel fistulae additionally managed)
  - Psychology
  - Patient Support Group
  - *Diverticulum: Urogynaecologist or Urologist with training & expertise in urethral reconstruction*

In summary, the main diagnostic codes for this service are ICD10, N820 and N821 and operative codes are OPCS4, P251 and P252.

2.3 Population covered

- The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in *Who Pays?: Establishing the responsible commissioner* and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).* - Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

- Specifically this service is for women experiencing any fistulous tract involving the bladder or urethra and the genital and/or gastro-intestinal tracts and peritoneal and/or cutaneous surfaces.
2.4 Any acceptance and exclusion criteria

- The service will accept referrals from GPs and secondary care clinicians in Gynaecology and Colorectal surgery. The service will also accept referrals from other providers, particularly when the referring service is not designated to undertake the clinical role the service requires.

- The service will accept referrals for patients who are experiencing any fistulous tract involving the bladder or urethra and the genital and/or gastro-intestinal tracts and peritoneal and/or cutaneous surfaces.

Exclusions
Patients with gynaecological cancer; their care is covered in the cancer services specifications

2.5 Interdependencies with other services

Urogynaecology, Urology, Coloproctology, Nursing, Physiotherapy, Nutrition and Psychology.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

- There are no currently available standards or evidence-based guidelines applicable in lower urinary tract fistulae from NICE, Cochrane or RCOG.

- An RCOG study group on incontinence published in 2002 made some recommendations on management and patterns of care.[6]

- The recent 1st International Consultation on Obstetric Vesicovaginal Fistula and 5th International Consultation on Incontinence reviewed current evidence on obstetric and non-obstetric fistula respectively; these are currently in press, but may be available for review as ‘academic in confidence’.[7, 8]
• The International Society of Obstetric Fistula Surgeons (ISOFS) has produced a number of standards for training, practice and centre accreditation in relation to obstetric fistula in the developing world;[9] in association with FIGO, the same group have developed a training manual.[10]

The development of skill in the management lower urinary tract fistulae could NOT be expected to be achieved from core training or from Advanced Training Skills Modules in Gynaecology or Urology. A modular training including periods in Urogynaecology, Urology and Coloproctology (as provided in some RCOG accredited Urogynaecology subspecialty training programmes), preferably supplemented by an attachment to a fistula unit overseas would be necessary.

Maintenance of skill requires the regular and consistent involvement in the management of a range of gynaecological and urological conditions, and a minimum of 3 and optimally 10 cases of lower urinary tract fistula per year.

4. Key Service Outcomes

• Results from treatment of lower urinary tract fistula vary widely in published literature. A recent analysis of outcomes from the HES database indicates re-operation rates varying between 0% and 50%.[3] Those units undertaking more than 30 procedures over 10 years achieved a significantly lower re-operation rates than those undertaking lower numbers (7.4% vs. 13.2%).[3]

• Although primary fistula repair is appropriate in most cases, a small number may require urinary diversion; this is more likely in women with gynaecological malignancy. The rate of urinary diversion in women with a diagnosis of lower urinary tract fistula also varies considerably, and may be seen as another measure of outcome. The overall rate of diversion in England is 25.5%.[3] whereas in the unit undertaking the largest number of fistula repairs nationally, the rate of diversion was only 2.7%.[1]

References:


### Service Pathway – Complex Gynaecology

**Lower urinary - genital tract fistulae; urethral diverticula***

*n.b. Where pathways differ, that for diverticula is shown in blue text*

<table>
<thead>
<tr>
<th>Referral Pathway type/source</th>
<th>Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary</strong></td>
<td><strong>Secondary</strong></td>
</tr>
<tr>
<td>General Gynaecology;</td>
<td>As primary; probably deferred by &gt;3 months</td>
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<tr>
<td>Urogynaecology; Urology;</td>
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<tr>
<td>General Practice</td>
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<thead>
<tr>
<th>Local referrals</th>
<th>Regional/Supra regional referrals</th>
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<tbody>
<tr>
<td>Initial out-patient appat at Supra-regional Urogynaecology/Urology Fistula Unit</td>
<td>Admission to Supra-regional Urogynaecology/Urology Fistula Unit</td>
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</tbody>
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Urogynaecologist or Urologist with training and expertise in fistula management working with MDT including Urogynaecology, Urology, Coloproctology, Nursing, Physiotherapy, Patient Support Group

Diverticulum: Urogynaecologist or Urologist with training and expertise in urethral reconstruction

<table>
<thead>
<tr>
<th>Outpatient Appointment (Detail? Assessment, MDT, Single Clinician etc)</th>
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<tbody>
<tr>
<td>Endoscopy: Cystourethoscopy (Ureteroscopy), Sigmoidoscopy, Colonoscopy</td>
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<tr>
<td>Functional Assessment: Urodynamics, Ano-rectal manometry, Nerve conduction studies</td>
</tr>
<tr>
<td>Imaging: CT/IVU, MRI, Ultrasound, Retrograde pyelography</td>
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<tr>
<td>Initial drainage procedures: Urethral or suprapubic catheterisation of bladder, retrograde ureteric stenting, nephrostomy, antegrade ureteric stenting</td>
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<tr>
<td>Diverticulum: Cystourethoscopy, urodynamics, MRI, ultrasound</td>
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<thead>
<tr>
<th>Investigations/procedures needed</th>
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<tbody>
<tr>
<td>Outpatient</td>
</tr>
<tr>
<td>Initial drainage procedures as above, in appropriate circumstances (best organised in discussion with Supra-regional Fistula Unit)</td>
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</tbody>
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<table>
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<tr>
<th>Treatment Strategy (please provide detail)</th>
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<table>
<thead>
<tr>
<th>Site: Supra-regional Fistula Unit</th>
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<tbody>
<tr>
<td>Timing: Dictated by aetiology and nature of fistula</td>
</tr>
<tr>
<td>Further assessment: EUA/Cystoscopy (possible retrograde pyelography) followed (within days) by:</td>
</tr>
<tr>
<td>Repair Surgery: Vaginal (+/- interposition), colpocleisis, abdominal transvesical or transperitoneal (+/- interposition), ureteric re-implantation, urinary diversion (ileal conduit or continent)</td>
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<tr>
<td>Diverticulum: vaginal (+/- interposition) only</td>
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<tr>
<th>Inpatient</th>
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<tbody>
<tr>
<td>Site: Supra-regional Urogynaecology/Urology Fistula Unit (where feasible); Local (referring) hospital (where repeat travel difficult)</td>
</tr>
<tr>
<td>Timing: 6-8 weeks following repair (unless adverse events/outcomes)</td>
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<tr>
<td>Follow up (detail)</td>
</tr>
<tr>
<td>Further investigations/treatments required (detail)</td>
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<tr>
<td>Imaging: Cystogram/CT IVU</td>
</tr>
<tr>
<td>Further assessment: EUA/Cystoscopy</td>
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*note: The pathway for diverticula is shown in blue text*