

Management of patients with rectocele

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A B S T R A C T

The main objective of this article is to review the management of patients with posterior vaginal wall prolapse. The posterior vaginal wall is inconsistent both in terms of correlating patient symptoms to objective findings and correlating correction of anatomic defects to symptom relief. Therefore, the management of patients with pelvic organ prolapse is challenging and emphasizes the need for surgeons to clearly communicate expectations of surgical repair. Despite these limitations, surgical repair of pelvic organ prolapse in properly selected patients can provide symptomatic relief and improvement in their quality of life and functional status. Review of the literature suggests that traditional posterior colporrhaphy without levatorplasty has superior objective outcomes compared with site-specific posterior repair (grade B), there is a higher dyspareunia rate reported when levatorplasty is employed (grade C), the transvaginal approach is superior to the transanal approach (grade A), there is no benefit of mesh overlay or augmentation of a suture repair (grade B), and while modified abdominal sacrocolpopexy results have been reported, data on how these results would compare with traditional transvaginal repair are lacking. Further studies are needed to optimize the care of patients with posterior vaginal wall prolapse.

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Introduction

Pelvic organ prolapse is defined by the International Continence Society (ICS) as the descent of one or more of the following structures: the anterior or posterior vaginal wall, the apex of the vagina, or the vault.¹ The overall prevalence of pelvic organ prolapse is relatively high and found in 41–50% of women. However, the prevalence of clinically significant pelvic organ prolapse (i.e., patients with large, symptomatic defects) is much lower ranging between 3% and 6%.^{2–5} In other words, the majority of women with prolapse are asymptomatic. Anterior compartment prolapse is the most frequently reported site and is reported twice as often as posterior compartment defects and three times more often than apical prolapse.⁶ The peak incidence of symptomatic pelvic organ prolapse in the United States occurs in women between the ages of 70 and 79, but still affects around 30% of younger women as well.⁷ Vaginal birth, advanced age, and obesity are the most consistently reported risk factors for developing pelvic organ prolapse.^{4,8}

Symptoms from pelvic organ prolapse can vary depending on the type of prolapse but in general can be broken down into bulge

symptoms (sensing a perineal bulge or heaviness), urinary symptoms (incontinence, frequency, urgency, hesitancy, weak stream, incomplete emptying, or manual reduction of prolapse to start or complete voiding), bowel systems (fecal incontinence, incomplete emptying, straining, urgency, digital evacuation, feeling of obstruction during defecation), sexual symptoms (dyspareunia, decreased lubrication, sensation, arousal, or orgasm), and pain symptoms (vagina, bladder, rectum, pelvic, lower back).⁹ For some patients, the symptoms from pelvic organ prolapse can quite debilitating, greatly reducing their quality of life and functional status.⁷ For example, simple exercises such as walking may be avoided due to bulge or pain symptoms. For these patients, surgical repair can be of great value as there is evidence that after surgery, women have clinically significant improvement in vitality, mental health, social functioning, and role-emotion.¹⁰ Pelvic organ prolapse is a broad topic with a vast amount of literature making a comprehensive review difficult. Patients affected by this condition will often seek help from numerous specialties including primary care physicians, gynecologists, and colorectal surgeons. The purpose of this article is to highlight key principles in management and treatment of rectocele, enterocele, and sigmoidocele (Fig. 1).

The American Society of Colon and Rectal Surgeons (ASCRS) defines a rectocele as a herniation of the anterior wall of the rectum into the posterior wall of the vagina.¹¹ An enterocele is defined as a herniation of the peritoneum containing small bowel

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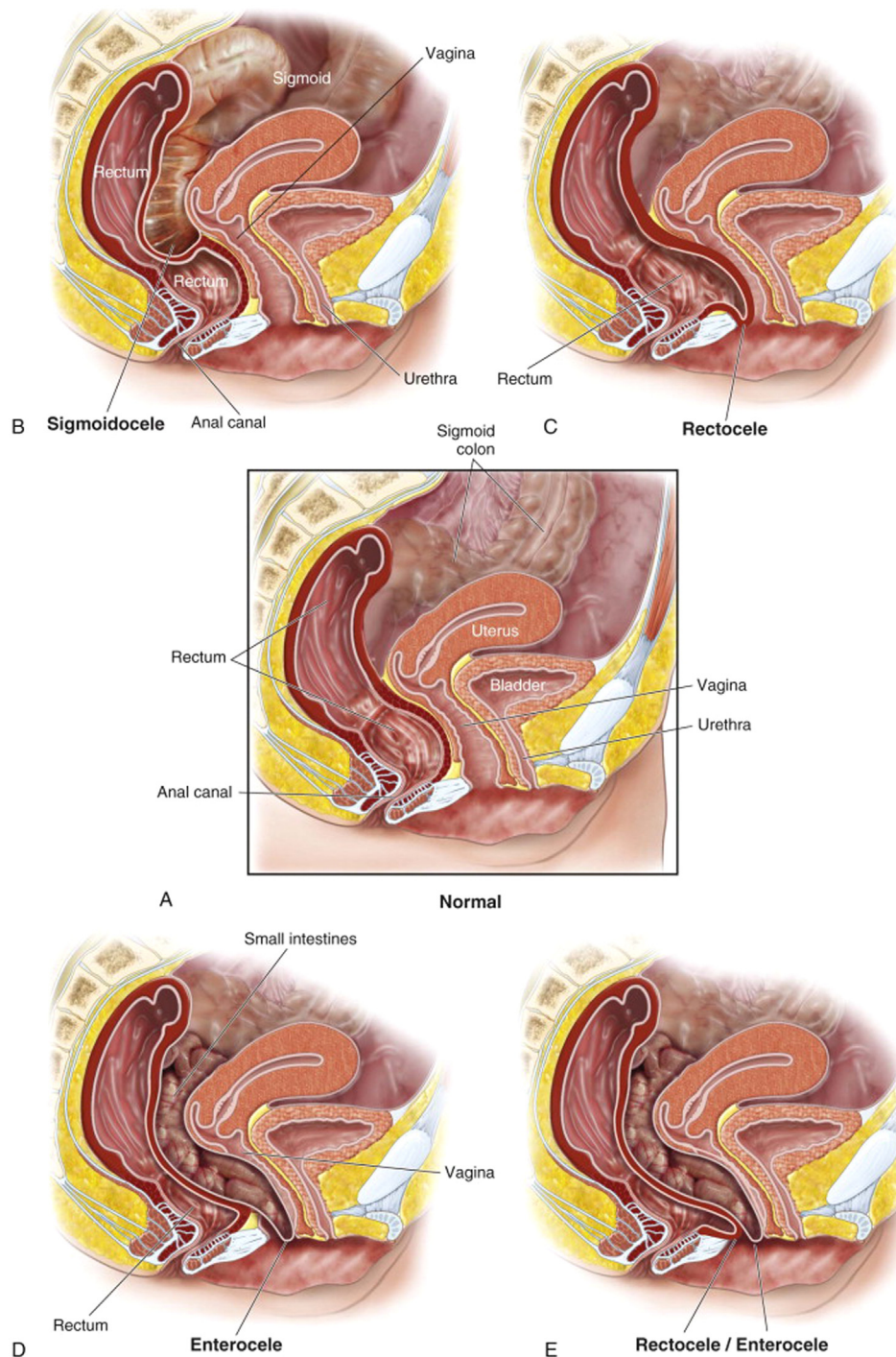


Fig. 1. Types of posterior pelvic organ prolapse. (Reprinted with permission from Ref. ⁶⁸.)

through the pelvic floor, usually between the vagina and rectum.¹² Similarly, a sigmoidocele is a herniation of peritoneum containing sigmoid colon through the pelvic floor, usually between the vagina and rectum.¹² While these entities can occur in isolation, they commonly occur in combination.¹³ From a colorectal surgeon's perspective, it is important to note that posterior vaginal wall prolapse co-exists with anterior or apical prolapse in up to 50% of patients.¹³

Anatomy of the posterior vaginal wall

A basic understanding of the anatomy of the posterior vaginal wall support structures is necessary in order to understand the

surgical management of pelvic floor defects. Connective tissue support of the vagina as a whole can be divided into three levels as described by DeLancey¹⁴ in 1992. Level I structures provide support to the uppermost or apical portion of the posterior vaginal wall and include the cardinal and uterosacral ligaments. Level II structures provide support to the middle portion of the vagina and include the endopelvic fascia and its attachments connecting the posterolateral vaginal wall to the aponeurosis of levator ani muscle. Lastly, level III structures provide support to the distal portion of the vagina and include the perineal body composed of interlacing muscle fibers from the bulbocavernosus, transverse perineal, and external anal sphincter muscles (Fig. 2).

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