

Posterior Compartment Prolapse: A Urogynecology Perspective

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KEYWORDS

- Posterior compartment prolapse • Posterior colporrhaphy • Rectocele • Enterocele
- Perineorrhaphy

KEY POINTS

- Symptomatic women of posterior compartment prolapse may present with complaints of vaginal bulge, constipation, tenesmus, splinting, and fecal incontinence.
- A clinical examination is generally sufficient in the workup of posterior compartment prolapse, and imaging studies should be reserved for cases whereby symptoms do not correlate with the physical examination.
- Defecatory dysfunction, quality of life, and sexual function can significantly improve after surgical repair with either traditional or site-specific colporrhaphy.

INTRODUCTION

In 2010 an estimated 166,000 women underwent surgical repair for pelvic organ prolapse.¹ Of these women, an estimated 52% had a rectocele procedure as part of their repair.² In women undergoing rectocele repair, the most common presenting symptoms beyond vaginal bulge are those of defecatory dysfunction, including constipation (46%), tenesmus (32%), splinting (39%), and fecal incontinence (13%).³ In addition, dyspareunia is present in 29%. Although the symptoms of posterior vaginal prolapse do not directly correlate with the degree of the prolapse,⁴ repair of a rectocele alleviates the associated symptoms in most patients.⁵⁻⁷

WORKUP

Clinical Examination

The pelvic examination is performed in the dorsal lithotomy position. The posterior wall is assessed while supporting the vaginal apex and anterior wall with a separated posterior blade of a bivalve speculum. The authors currently use the Pelvic

Organ Quantification System (POPQ) to objectively measure prolapse during maximal Valsalva effort (**Fig. 1**).⁸ The POPQ system has been adopted by the American Urogynecologic Society, Society of Gynecologic Surgeons, International Urogynecological Association, and International Continence Society.⁹

The POPQ measurements Ap and Bp measure the posterior vaginal wall. Point Ap is located in the midline of the posterior vaginal wall, 3 cm proximal to the posterior hymen. The quantitative value of point Ap is anywhere from -3 to +3 cm from the hymeneal ring, depending on the extent of posterior wall prolapse. Point Bp is the most distal (ie, most dependent) position of any part of the upper posterior vaginal wall between point Ap and the vaginal cuff or posterior vaginal fornix. This value can range from -3 (no prolapse) to more than +3 (up to the total vaginal length) if associated with a vault prolapse beyond the hymeneal ring.

A rectal examination aids in detecting specific defects in the posterior vaginal wall and can help identify an enterocele or sigmoidocele. In addition, one can evaluate for an enterocele by evaluating

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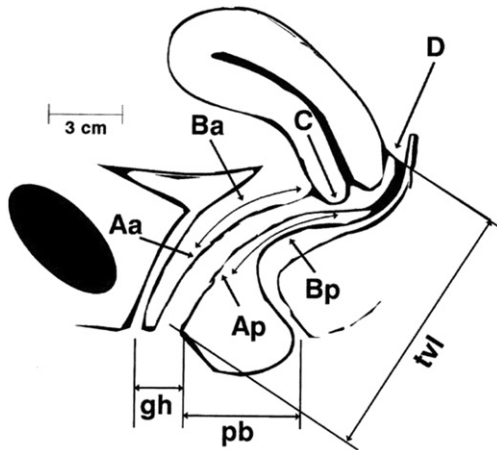


Fig. 1. Six sites (points Aa, Ba, C, D, Bp, and Ap), genital hiatus (gh), perineal body (pb), and total vaginal length (tvl) are used for quantification of pelvic organ support. (From Bump RC, Mattiasson A, Bø K, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol* 1996;175(1):10; with permission.)

the patient in a standing position because the small bowel will enter the enterocele sac. It is also important to evaluate for rectal intussusception or rectal prolapse. In addition, a rectal examination can help evaluate the integrity of the perineal body and anal sphincter tone.

Imaging

A thorough clinical examination is an accurate way of evaluating for posterior compartment defects. Imaging studies are occasionally useful if there is a concern for other abnormality, or if there is recurrent posterior compartment prolapse. The use of ancillary studies may also be helpful for patients who complain of fecal incontinence or report defecatory dysfunction and do not have a posterior compartment prolapse on clinical examination.

Defecography

Defecography provides a 2-dimensional view of rectal emptying efficiency and allows for the quantification of rectal measurements. The size of the rectocele is determined by measuring the distance between the anterior border of the anal canal and the maximal point of the bulge of the rectal wall into the posterior vaginal wall. Anything less than 2 cm is considered normal, and a rectocele is considered large if the rectal wall protrudes more than 3.5 cm.¹⁰⁻¹² The clinical utility of defecography is limited, and diagnosis of anterior rectocele correlates with level of experience of the person reading the test.¹³ One study of elderly patients

found no association between abnormalities found on defecogram and symptoms.¹⁴ Another suggested only a limited correlation between the radiologic findings and clinical outcomes after surgical repair.¹⁵ The authors do not typically obtain defecography studies unless they are considering a diagnosis of pelvic floor dyssynergia, whereby the puborectalis or external anal sphincter muscle is paradoxically contracted on rectal examination, or identifying a sigmoidocele.

Magnetic Resonance Imaging

Dynamic magnetic resonance imaging (MRI) offers high-quality images of the pelvic soft tissues and viscera, and can be used to evaluate posterior compartment prolapse. However, the lack of standardization in grading posterior prolapse, the high cost of MRI, and its poor correlation with clinical staging makes its routine use problematic.^{16,17} MRI does continue to be used in the research setting. Because clinical examination has a high sensitivity for detecting rectoceles, the authors generally do not order MRI for the routine evaluation of posterior compartment prolapse.

Endoanal Ultrasonography

On clinical examination, diminished resting or squeeze tone of the distal anal canal and suspicion of a sphincter disruption may prompt an endoanal ultrasonogram. This modality can aid in the detection of a sphincter defect (either internal or external), and also allows visualization of the puborectalis muscle.¹⁸ The finding of a defect in the sphincter complex in an appropriate patient with complaints of fecal incontinence may prompt consideration of a sphincteroplasty.

TREATMENT

Treatment should be pursued only if the patient's prolapse is symptomatic. She should be counseled regarding potential outcomes with expectant management and pessary use. Pessary fittings have been found to be successful in the treatment of symptomatic pelvic organ prolapse. In one study of 100 consecutive patients with symptomatic pelvic organ prolapse, pessaries were successfully fitted in 73% of patients, with 92% still being satisfied at a 2-month follow-up. Patients successfully fitted with pessaries noted significant decreases in vaginal bulge (90% down to 3%; $P < .001$), pressure (49% down to 3%; $P < .001$), and splinting to defecate (14% down to 0%; $P = .001$).¹⁹ The authors offer virtually all of their patients a pessary trial before discussing the possibilities of surgical treatment.

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