43.Schweizerische Koloproktologie-Tagung
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The anterior rectocele: gynecologist's perspective

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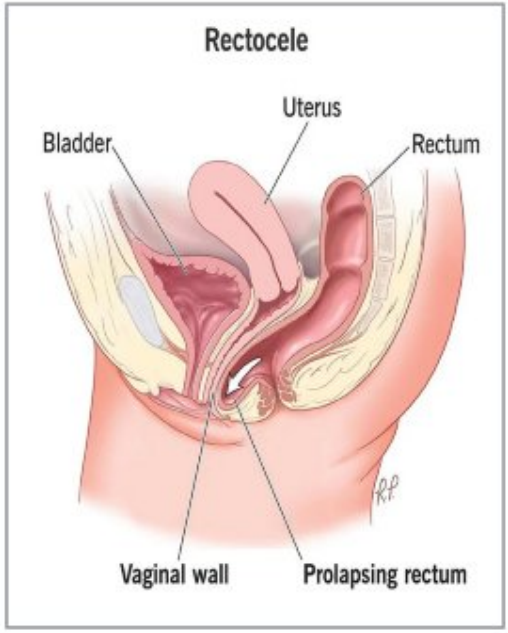
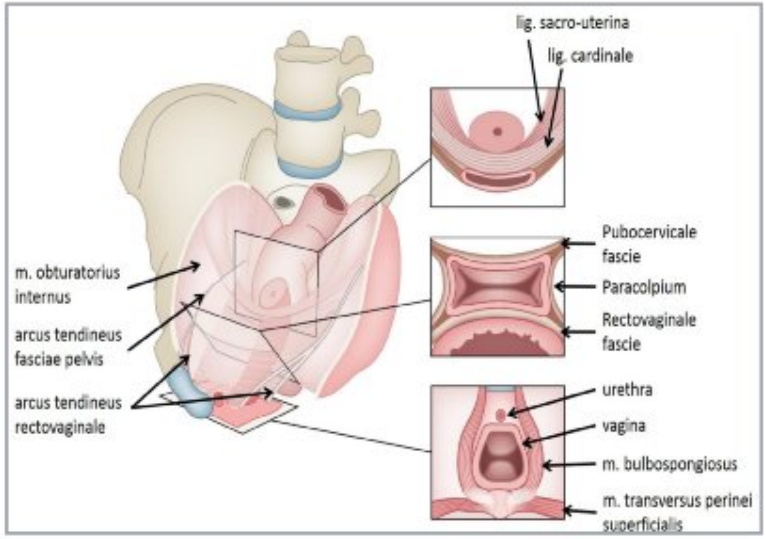
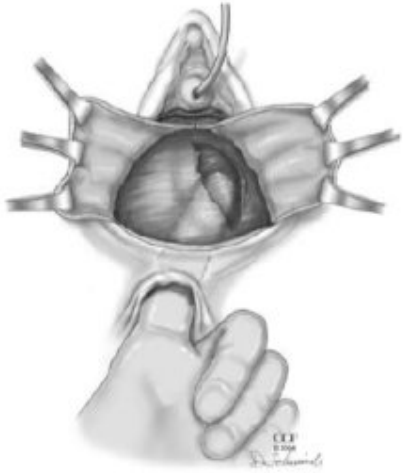
Anterior rectocele



- Most common type of pelvic floor weakness in the posterior compartment
- Very often seen in the gynecological examination, especially in women after childbirth
- Posterior vaginal wall prolapse caused by defect of endopelvic fascia (rectovaginal septum) with herniation of rectal tissue
- Evaluation is largely clinical
- Treatment depends on extent of the prolapse and severity of symptoms

Delancey's 3 levels of vaginal support





– Vaginal prolapse surgery = „fascial (defect) repair"

Risk factors for posterior vaginal defects

- Vaginal childbirth
  - Multiparity
  - High infant birth weight
  - Prolonged second stage of labor
- Advancing age
- Obesity/Increasing body mass index
- Chronically elevated intraabdominal pressure (e.g. COPD)
- Burch colposuspension in the past
- Hysterectomy in the past
- Collagen abnormality
- Menopause
- Positive family history

Clinical manifestations

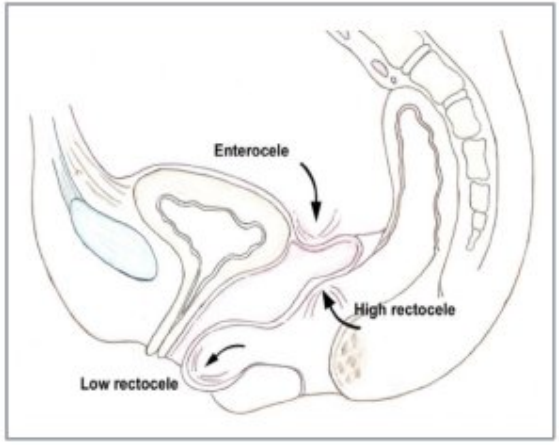
- Most patients are symptom-free!
- Need for treatment
  - Prolapse-associated symptoms
    - Bulge or vaginal pressure symptoms, vaginal pain
    - Sensation of vaginal laxity and/or increasing width of the introitus
    - Sexual dysfunction, dyspareunia
    - Obstructed voiding
  - Obstructed Defecation Syndrome (ODS)
    - Constipation
    - Feeling of incomplete emptying, straining to defecate
    - Digital pressure to the vagina or perineum (splinting)
    - Repetitive defecation

      → Interdisciplinary management with coloproctology

Diagnosis: clinical evaluation

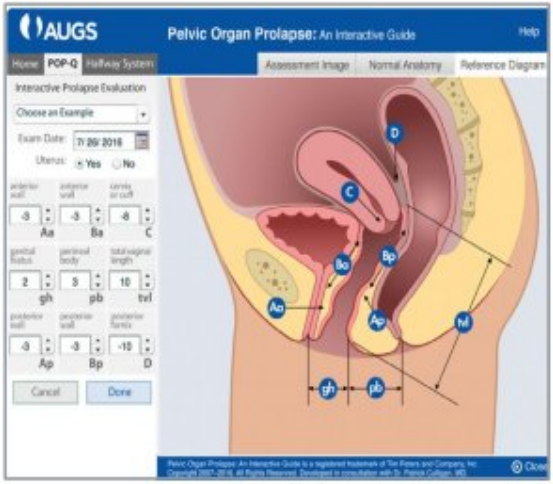
- Dorsal lithotomy position
- Visualization of the posterior vaginal wall using a speculum or single retractor
- Increase of abdominal pressure with a Valsalva maneuver (maximum degree of prolapse)
- Stage of prolapse (POP-Q system)
- Length and condition of the perineal body
- Rektovaginal examination
- Pelvic floor muscle testing (Oxford scale)
- Assessment of the anal sphincter

Diagnosis: low/high rectocele, recto-/enterocele



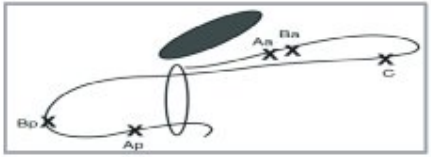
- Distinguishing between an enterocle and rectocele may be challenging
- Degree of anatomic distortion does not correlate with functional impairment

POP-Q system (Pelvic organ prolapse quantification system)



The five stages of prolapse

- Stage 0: No prolapse
- Stage I: The most distal portion of the prolapse is >1 cm above the level of the hymen
- Stage II: The most distal portion of the prolapse is ≤1cm proximal or distal to the hymen
- Stage III: The most distal portion of the prolapse is >1 cm below the hymen but protrudes no further than 2 cm less than the total length of the vagina
- Stage IV: Complete eversion of the vagina



Rectocele

- The POP-Q system is an objective, site-specific system for describing and staging POP in women
- Quantitative measurements of various points representing anterior, apical and posterior vaginal prolapse to create a «topographic» map of the vagina

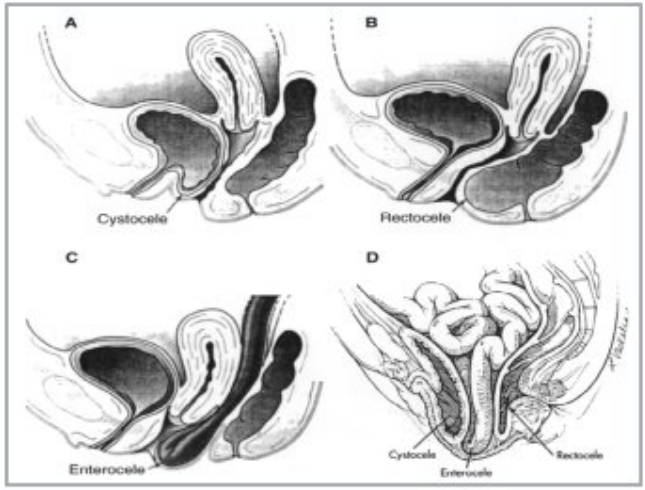
Further defects of the posterior compartment

- Enterocele (Hysterectomy in the past)
- Anal prolapse
- External rectal prolapse
- Internal rectal prolapse (Intussusception)
- Perineal descent

- Anal sphincter defects

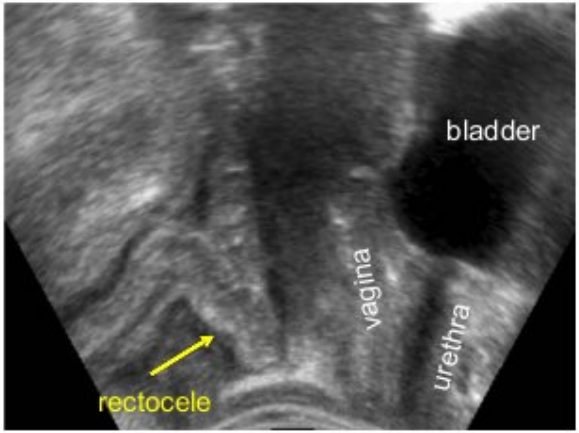
Defects of the anterior and apical compartment

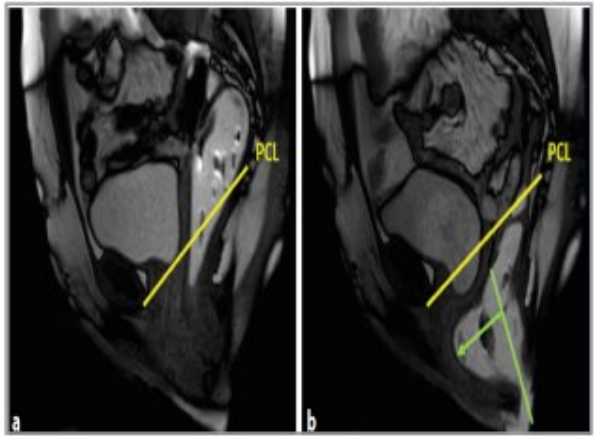
- Cystocele
- Uterine prolapse, Vaginal vault prolapse
  - Apical prolapse often associated with enterocele



Imaging

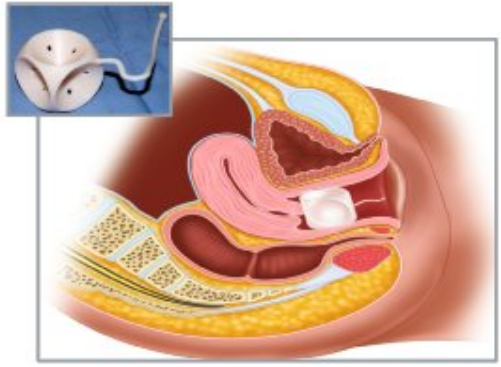
- Pelvic-Floor-Sonography (Introitus- and/or Perineal-Sonography)
  - Differentiation between recto-/enterocele possible
- Further radiological imaging (e.g. obstructed defecation)
  - MRI defecography (dynamic MRI)





Conservative management

- First line option for all women with POP
- Surgical management only in case of symptomatic rectocele
  - Treatment of bowel symptoms (e.g. dietary modifications, laxatives)
  - Local estrogen in combination with vaginal pessary (cube pessary)
  - Pelvic floor muscle training (PFMT)

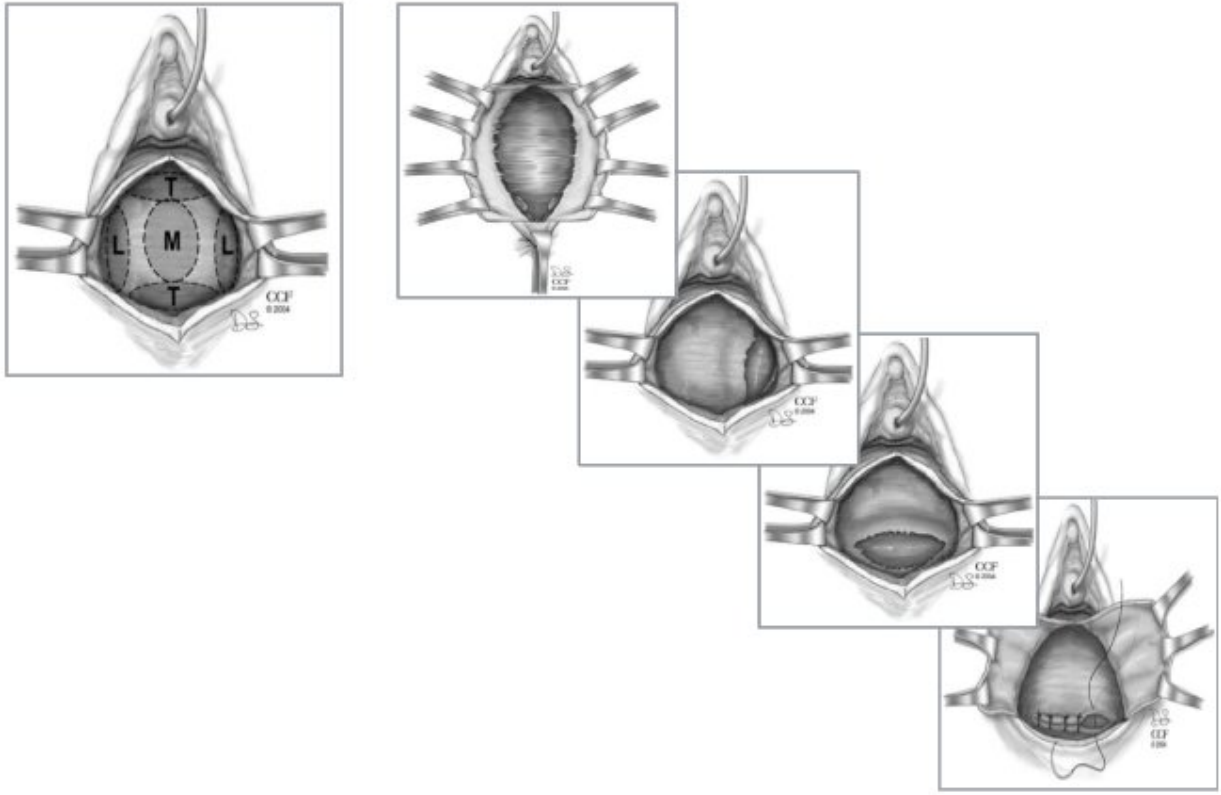


Surgical management

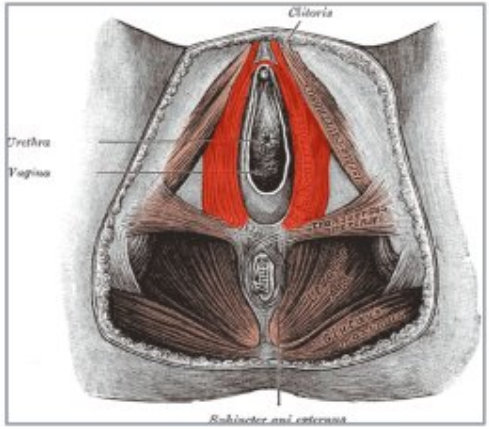
- The goal of rectocele repair is to relieve symptoms based on the fascial defect in the posterior vaginal wall (functional versus anatomic results!)
- Gynecologists typically perform a transvaginal repair (versus transanal approach in coloproctology)
- There are two methods of transvaginal rectocele repair
  - The (traditional) posterior colporrhaphy (midline plication)
  - The site-specific repair
    - In both techniques a perineorrhaphy is typically included
    - Both techniques can be performed using synthetic meshes
- Laparoscopic/Robotic procedures
  - These approaches can be performed when the rectocele is accompanied by apical prolapse, using synthetic meshes

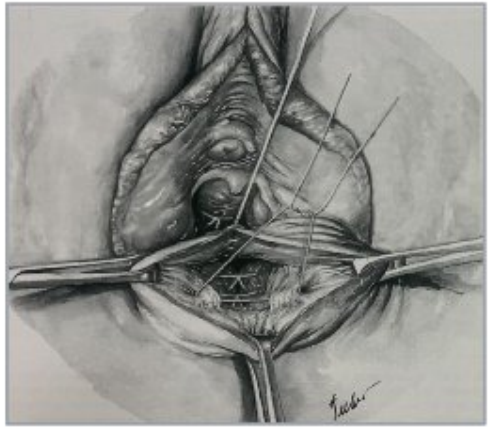
Posterior colporrhaphy («midline plication»)

Site-specific repair



Perineorrhaphy





- Effective option especially for older women with a wide introitus and without sexual intercourse
- The bulbocavernosus muscles are plicated in the midline of the perineal body
- Aggressive perineorrhaphy can cause dyspareunia

Guidelines of the SGGG, OEGGG und DGGG

- The posterior colporrhaphy is more effective than the site-specific repair (success rates 86 vs. 70%) and should be reserved for primary treatment
- Levator ani plication likely contributes to de novo dyspareunia and should not be performed in sexually active women
- The posterior colporrhaphy more effective than a transanal approach concerning anatomic and functional success rates

Transvaginal meshes in POP repair

- The use of transvaginal (synthetic) meshes in POP repair is controversial
- FDA warnings in 2008 und 2011 in response to increased reporting of mesh-related adverse events (2016: reclassification of transvaginal meshes as high-risk devices class III)
- 2018 Ban of all transvaginal meshes in Australia, New Zealand, Scotland and England

- The most common complications of transvaginal mesh placement
  - Mesh exposure, mesh shrinking, pain, infection, urinary problems, organ perforation

Transvaginal meshes in rectocele repair

gynécologie suisse

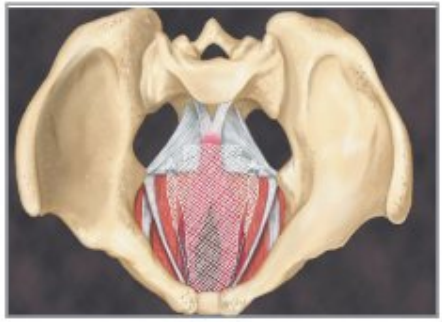
Expertenbrief No. 61 (ersetzt No. 21 vom 20.08.2012)

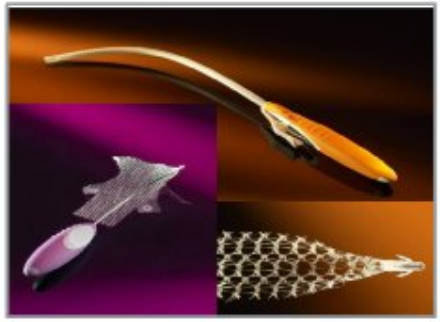
Kommission Qualitätssicherung
Präsident Prof. Dr. Daniel Surbek

Der Einsatz von Netzen bei Senkungsoperationen

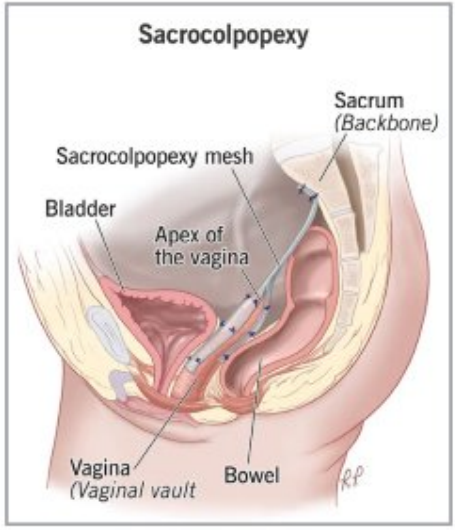
Autoren: G. Schär, V. Viereck, A. Kuhn, P. Dällenbach, C. Betschart, D. Faltin
Arbeitsgemeinschaft für Urogynäkologie und Beckenbodenpathologie AUG

- Correlates with lower rate of recurrence
- Should not routinely be performed as primary surgical repair due to risk of mesh-related complications
- May be considered
  - Rectocele recurrence
  - High grade of prolapse
  - High rectocele, concomitant enterocele





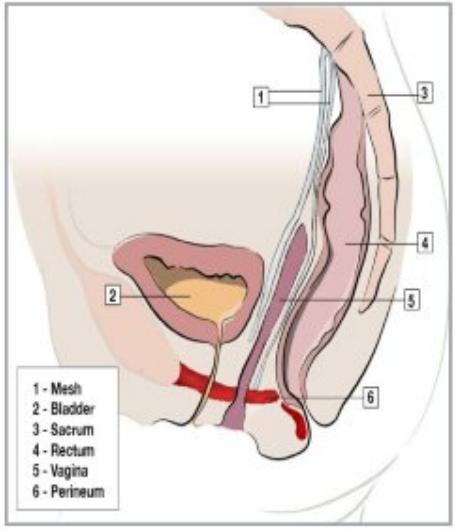
Laparoscopic/robotic approach: Sacrocolpopexy (SCP)



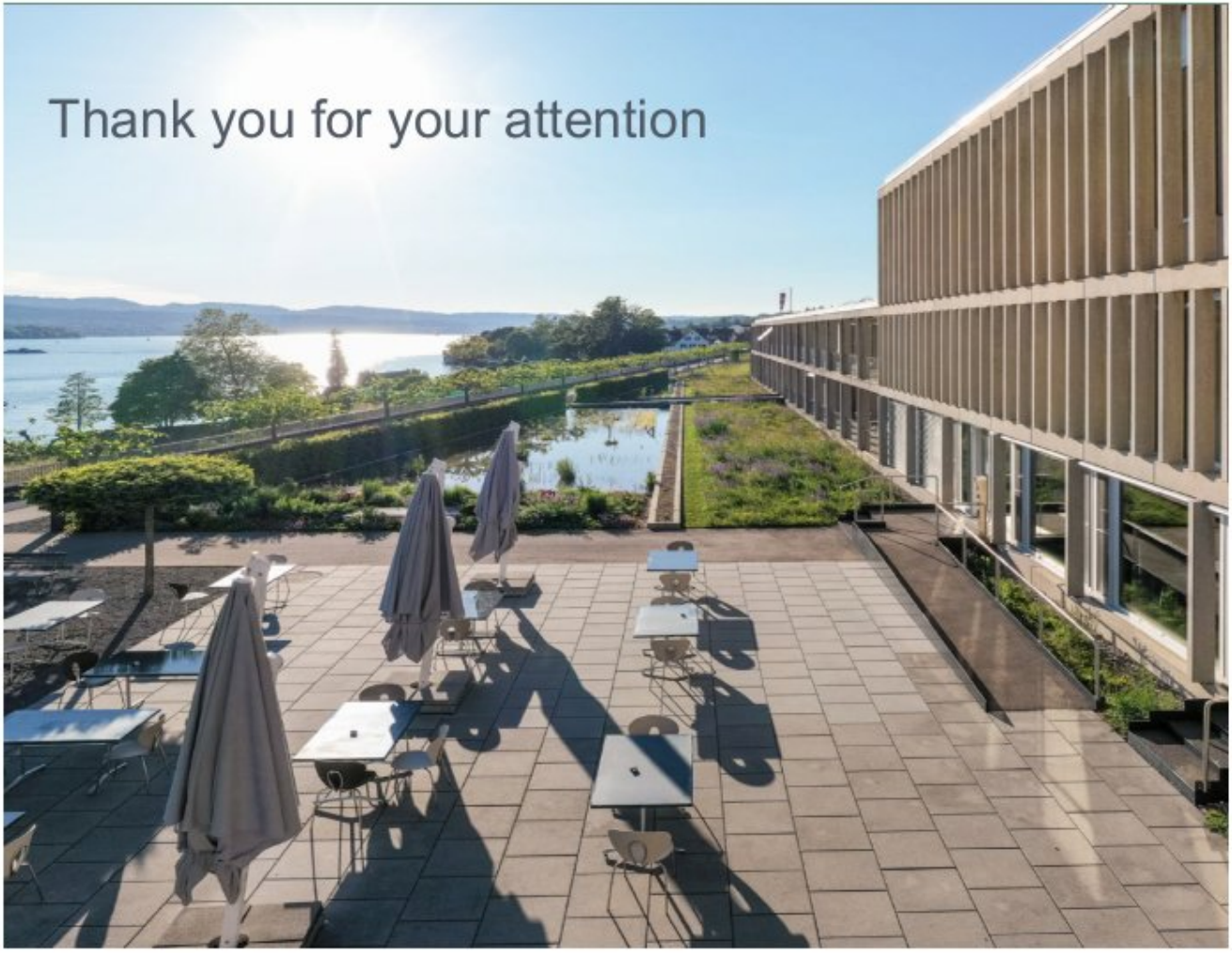
- Patients with apical prolapse are more likely to have anterior prolapse and less likely to experience posterior prolapse
- It is controversial whether repair of apical prolapse alone is sufficient to support the anterior and posterior vaginal wall
- Repair of anterior or posterior prolapse alone has a higher failure rate than when these procedures are combined with apical prolapse repair (importance of apical vaginal support!)

→ Repair of apical defect (Level 1) with correcting cystocele, rectocele and enterocele

SCP: Concomitant repair of posterior prolapse



- Repair of posterior vaginal wall prolapse at the time of sacrocolpopexy can be performed in different ways
  - Extending the posterior mesh down the rectovaginal septum (to the lower half of the vagina), if necessary extending down to the perineal body
  - Additional posterior colporrhaphy
  - Additional transvaginal mesh for the posterior compartment?
  - In case of perineal descent additional perineorrhaphy


Thank you for your attention