INTRODUCTION

Rectocele is defined as an abnormal bulging of the anterior rectal wall into the vagina, which is occasionally diagnosed in middle-aged or elderly females who complain of chronic constipation. It is sometimes encountered incidentally at the time of vaginal or rectal examinations. Rectocele treatment is designed to reduce specific symptoms, such as difficult evacuation, incomplete evacuation, and digital support during defecation. A lumpy vaginal protrusion, vaginal bulging, and pelvic heaviness also are important symptoms that indicate the need for treatment. Conservative management, including biofeedback training, can be helpful for patients with mild symptoms. If conservative management fails to relieve the symptoms, surgical treatment is advocated. What constitutes the optimal procedure has been discussed for years among colorectal surgeons and urogynecologists. A large variety of surgical techniques are available for the treatment of rectocele, including transvaginal, transperineal, endorectal, transabdominal, and combined approaches. In addition to the surgical technique itself, in numerous studies the question of using synthetic material for the repair of pelvic organ prolapses is addressed. Endorectal rectocele repair has been performed by colorectal surgeons. However, the results of endorectal repair have been reported with varying success. In addition, some authors have suggested that the endorectal approach might deteriorate anal sphincter function. Transvaginal rectocele repair has been used mainly by gynecologists as a posterior colporrhaphy. This consists of the plication of the levator muscles or the plication of the rectovaginal fascia. Although clinical results after transvaginal rectocele repair have been widely reported, the physiologic influences after transvaginal rectocele repair have not been fully investigated.
CASE REPORT

On our Surgical clinic we examined 67 years old women with incomplete evacuation, and digital support during defecation, giant rectocele and massive vaginal vault prolaps. We are realized cinedefecography and detected giant rectocele depth 8 cm, anorectal angle was 120 degrees. Dynamic magnetic resonance imaging defecography we have not ability carry out. We are stated Resting pressure 40 cm H2O, and Maximum squeeze pressure 50 cm H2O by anorectal manometry. We verified external anal sphincter defect by endoanal ultrasound and determined Pudendal nerve terminal motor latency (PN TML) and recorded pathologic values of n.pudendal latency (left branch 2,7 msec., right branch 4,3 msec). In concerning massive vaginal vault prolaps, huge rectocele and clinical incompletely evacuation with self digital support during defecation with present defect of external anal sphincters and pathologic values of PN TML, we indicated and made combined transvaginal, endorectal and perineal reconstructive operative performance.

OPERATIVE TECHNIQUE

One day before surgery was administered ortograde lavage with A.B. Taylor solution. In the morning on the day of surgery enema was administered. A systemic antibiotic was given immediately before the operation commenced. The operation was performed in two position. At he first in the dorsal lithotomy position under spinal anesthesia.
Both sides of the labia major were sutured laterally for better exposure (pct. 1). The posterior vaginal mucosa was infiltrated with an epinephrine solution to minimize bleeding during dissection. A U-shaped incision was made in the posterior wall of the vagina along the lower one-half of the vaginal introitus. The vaginal mucosa was then freed from the underlying rectal wall with a sharp dissection by using scissors (pct. 2).

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In that case, care was taken not to remove too much mucosa to avoid postoperative constriction. The midline of the vaginal mucosa was approximated with intermittent delayed absorbable sutures (0-Coated Vicryl, Ethicon Inc.) and both sides of the lateral border were sutured with intermittent delayed absorbable sutures (000-Coated Vicryl, Ethicon Inc.) (pct. 5). No drain was placed inside and one piece of gauze was packed. After that we lead so called "smile incision", semicircular cut along the rear perimeter of the perineum followed by the proximal intersphincteric preparation, and made Levator plasty anterior can be easily performed using this special perineal operative approach (pct. 6).

We changed position of the patient in Jack-knife position and made endorectal repair of rectocele (pct. 10). Anal mucosa is incised transversely 1 cm above the dentate line and dissected from the internal anal sphincter and the rectal circular muscle to a height of 10 cm (pct. 11). We sutured rectal mucosal layer is concertinaed together (3-0 Vicryl Ethicon Inc.) (pct. 12). In addition we lead left parasacral skin incision (pct. 7) and made "releasing posterior" (pct. 8), reffing of the m. puborectalis (pct. 9) and overlap plasty "scar over scar". We inserted one silikone drain under the suture (pct. 13,14). In order to prevent tromboembolic complications, the patient was given low molecular Heparin. The patient was given intravenous solutions without amino acids and fats until the fourth day and then fed orally.

RESULT
There was no intraoperative rectal wall injury. No early postoperative complications, such as bleeding, hematoma, or wound infections were observed. The patient underwent a clinical examination, anal manometry, cinedefecography, PN TML and anal ultrasound at 3 and 6 months and 1 and 2 years after surgery. In the present time two years after the surgery Continence grading scale score is 4 points. Radiologic mean depth of the rectocele was significantly reduced (preoperatively 8 cm, postoperatively 1 cm). Anorectal angle is 100 degrees. Values of the PN TML is normally (left branch of n. pudendalis 1,7 msec and right branch of n. pudendalis 1,9 msec). We recorded Resting pressure 60 cm H2O and Maximum squeeze pressure 110 cm H2O by anorectal manometry. We didn’t visualized any external anal sphincters defect by anal ultrasound. Postoperatively difficult evacuation completely disappeared and digital support was no longer necessary during evacuation.

DISCUSSION

Rectocele refers to displacement of the anterior rectal wall and the posterior vaginal wall into the vagina. The pathogenesis of rectocele is not well known. It seems to be considered that defects or tissue weakness in the rectovaginal septum are initially caused by vaginal delivery, and then aggravated by repetitive increase of intrarectal pressure. Neurodegenerative disorders and connective tissue diseases also might be of importance for the etiologic factors, which might be the cause of rectocele in nulliparous women. Rectocele often coexists with other pelvic organ prolapses, such as cystocele, vaginal vault prolapse, and enterocele. Generally, 3 cm is defined as abnormal bulging and considered to be an indication for surgical repair if it is symptomatic. Some authors advocate that barium trapping on defecographic findings also is a good indicator. The clinical implication of a coexistent finding of rectal intussusception or enterocele is not clear. Another aspect of coexistent problems concerning rectocele repair is paradoxic sphincter reaction or anismus. The role of this finding is debatable but one should bear in mind that some authors report that paradoxic sphincter reaction or anismus might be a cause of poor functional outcome.

What constitutes the optimal surgical approach has been debated for years. Endorectal rectocele repair was first reported by Sullivan et al. in 1968, and other surgeons followed or modified his procedure. However, endorectal rectocele repair has not always been successful. Transvaginal repair, known as posterior colporrhaphy, is reinforcement of the rectovaginal septum by the approximation of levator muscles (levatorplasty). This procedure has traditionally been performed by gynecologists. However, the possibility of dyspareunia is a well-known drawback of transvaginal repair. Incidences of dyspareunia have been variously reported at approximately 20 percent. Although many authors do not recommend this procedure for patients of childbearing age or sexually active women, they believe that transvaginal repair should not be avoided simply because it causes dyspareunia. The physiologic influence after rectocele repair is not well understood. Most studies do not investigate with anorectal physiologic tests. The endorectal approach usually needs an anal dilator for adequate rectal exposure during an operation, which could cause sphincter damage. Regarding rectal threshold and maximum tolerable volume, endorectal repair is more likely to decrease postoperatively. No significant changes have been reported in rectal compliance after endorectal or transvaginal repair. The transvaginal approach should be considered if the patient’s anal sphincter function is previously weakened. Recent publications describing new techniques using collagen mesh or a stapling device have received great attention from colorectal surgeons. I believe that the transvaginal repair bio implants seems to have more long-term effectiveness compared with biomaterial implants. Stapled transanal rectal resection (S.T.A.R.R.) became one of the recommended procedures for obstructed defecation syndrome over the last few years. The procedure, introduced by Longo, is...
characterized by endorectal performed full-thickness rectal wall resection. The S.T.A.R.R. procedure is based on the idea that removal of defunct parts of the rectal wall will improve obstructed defecation. The technique provides the opportunity to perform endorectal rectocele removal without the risks of transabdominal procedures. This novel technique seems to be safe and effective in the treatment of outlet obstruction caused by the combination of intussusception and rectocele. Randomized trials are required to confirm these findings.

CONCLUSION

In the case if old multiparous women have massive vaginal vault prolaps, huge rerectocele and clinical incompletely evacuation with self digital support during defecation and present defect of external anal sphincters and pathologic values of PN TML, combined one stage transvaginal, endorectal and perineal reconstructive operative performance is reasonable surgical modality with excellent result.

SUMMARY

KOMBINOVNI PARASAKRALNI, VAGINALNI I ENDOREKTALNI PRISTUP U HIRURŠKOM ZBRINJAVANJU TRETMANU GIGANTSKE REKTOKELE

Autori su na hirurškom odeljenju operisali ženu staru 67 godina sa tegobama u vidu nekompletne evakuacije i digitalnim pomaganjem u toku defekacije, sa verifikovanom gigantskom rektocelom i masivnim prolapsom vagine. Sprovedena je defekografija i otkrivena gigantska rektocela dubine 8 cm, sa anorektalnim uglom od 120 stepeni. Analnom manometrijom konstatovan pritisak u miru od 60 cm vodenog stuba, a pri voljnoj kontrakciji od 50 cm vodenog stuba. Endorektalnim ultrazvukom verifikovan defekt kontinuiteta analnih sfinktera, i latencu pudendanog motornog nerva (PN TML) i zabeležene su pathologic values of PN TML, combined one stage transvaginal, endorectal and perineal reconstructive operative performance is reasonable surgical modality with excellent result.

REFERENCES


