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Surgical Repair of Rectocele – Case Report

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Abstract
Background
Rectocele is the herniation of the rectum through the posterior wall of the vagina due to the loss of integrity of the rectovaginal fascia. Many parous women have a sort of pelvic organ prolapse, though most of the time this is asymptomatic. Over time, as the defect becomes larger, the patient may complain of constipation, difficult defecation, pelvic pain, mucosal erosion and the presence of a visible bulge. Among treatment options, dietary and lifestyle changes are recommended, medications, devices such as vaginal pessaries and surgical procedures.
Case presentation
Our 60 years old female patient was diagnosed 7 years before with rectocele. On the last 2 months it had reached considerable dimesions (grade III-IV). She complained of difficulty in urination and had a urinary catheter placed. The surgical procedure was proposed and patient consent obtained. A posterior colpo-perineorraphy was performed, without mesh placement. The patient made a full recovery and was discharged.
Discussion
The initial treatment of rectocele starts with the modification of the risk factors and relief of obstructive defecation syndrome. Patients are prescribed osmotic laxatives along with dietary changes for more fibre intake. Usage of pessaries, space occupying vaginal devices may be of help in select patients and it should be mentioned as a therapeutic alternative, though care must be taken to ensure proper usage as mucosal damage has been reported. The patients with severe and symptomatic rectocele should undergo a surgical intervention. From the list of possible approaches, we can mention: a) posterior colporraphy with the reinforcing of the rectovaginal septum, with or without the placement of a reinforcing prosthetic mesh. Some studies report higer recurrence rates where mesh was applied; b) transanal plication; c) transanal resection; d) abdominal suspension. Ultimately each of the procedures comes with the associated risks.
Conclusion
To conclude, it is the decision of the surgeon to find the best surgical approach for the treatment of rectocele. Not only he should be comfortable with the procedure, but care should be taken to achieve the full relief of the symptoms of the patient. For this specific case, due to the higher stage of rectocele, a posterior colporraphy, with the transvaginal plication of rectovaginal septum was chosen as a safe and efficient surgical approach.
Keywords: General Surgery, Rectocele, Perineum, Pelvic Floor, Colpo-perineorraphy, Colporraphy.
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1. Introduction

Rectocele is the herniation of the rectum through the posterior wall of the vagina due to the loss of integrity of the rectovaginal fascia. Many parous women have a sort of pelvic organ prolapse, though most of the time this is asymptomatic.

Although age, vaginal delivery, and genetics play an important role, some modifiable causes may lead to rectocele formation, such as constipation, chronic cough, increased abdominal pressure, obesity and a history of pelvic surgery.

Over time, as the defect becomes larger, the patient may complain of constipation, difficult defecation, pelvic pain, mucosal erosion and the presence of a visible bulge.

Among treatment options, dietary and lifestyle changes are recommended, medications, devices such as vaginal pessaries and surgical procedures.

2. Case presentation

2.1 History of present illness

Our 60 years old female patient was diagnosed 7 years before with rectocele. On the last 2 months it had reached considerable dimesions (grade III-IV). She complained of difficulty in urination and had a urinary catheter placed. The surgical procedure was proposed and patient consent obtained.

2.2 Details of the surgical procedure

The patient is placed in a lithotomy position. After a lavage of the vaginal space, a vaginal retractor is placed.

50ml of normal saline and lidocaine are injected under the posterior wall of the vagina, which helps in the division of the cleavage plane with the rectum.

Two clamps are placed in the posterior vaginal wall. With an electrocautery blade we make a longitudinal incision of the posterior vaginal wall, starting 2cm above the rectocele level, ending close to the inferior vaginal margin (this gives an inverted triangular shape opening).

With gentle pressure, to push away the rectum, using the index finger or a small sponge, we divide the posterior vaginal wall from the rectum. 4 clamps are positioned in the posterior vaginal wall. We continue suturing to approximate the levator muscles from both sides, with 2-0 vicryl. 4 such separate sutures are placed, where with one finger the rectum is pushed to avoid suturing it.

Parts of the posterior vaginal wall are resected and it is closed then with interrupted sutures, thus reinforcing this part. No mesh was inserted. The procedure ends with the placement of a vaginal gauze.

2.3 Post-operative period

The vaginal gauze and the urinary catheter were removed the next day. The patient made a full recovery and was discharged in good health in the 2nd postoperative day.

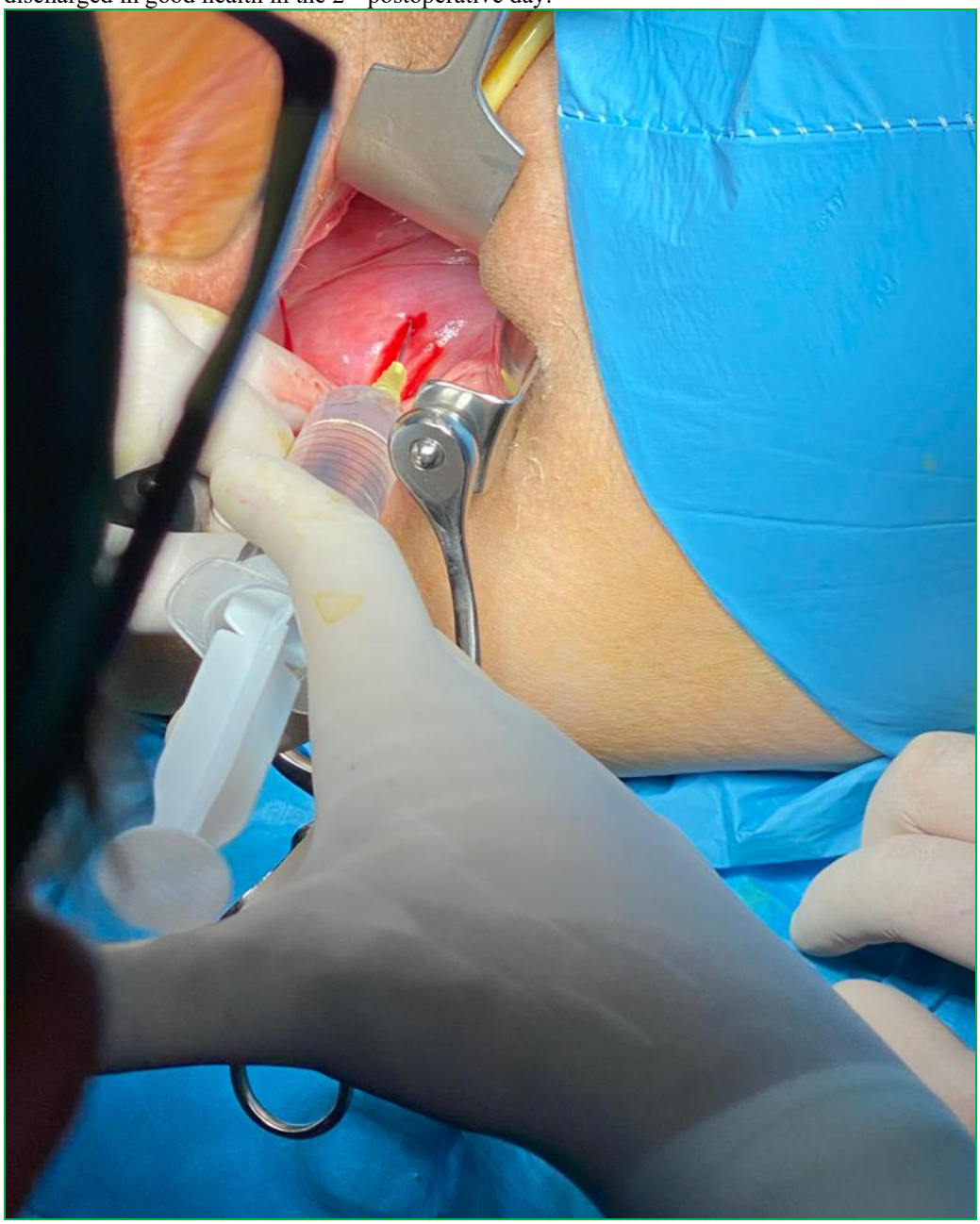

Figure 1. Injecting a 50ml mix of normal saline and 2% lidocaine under the posterior wall of the vagina.

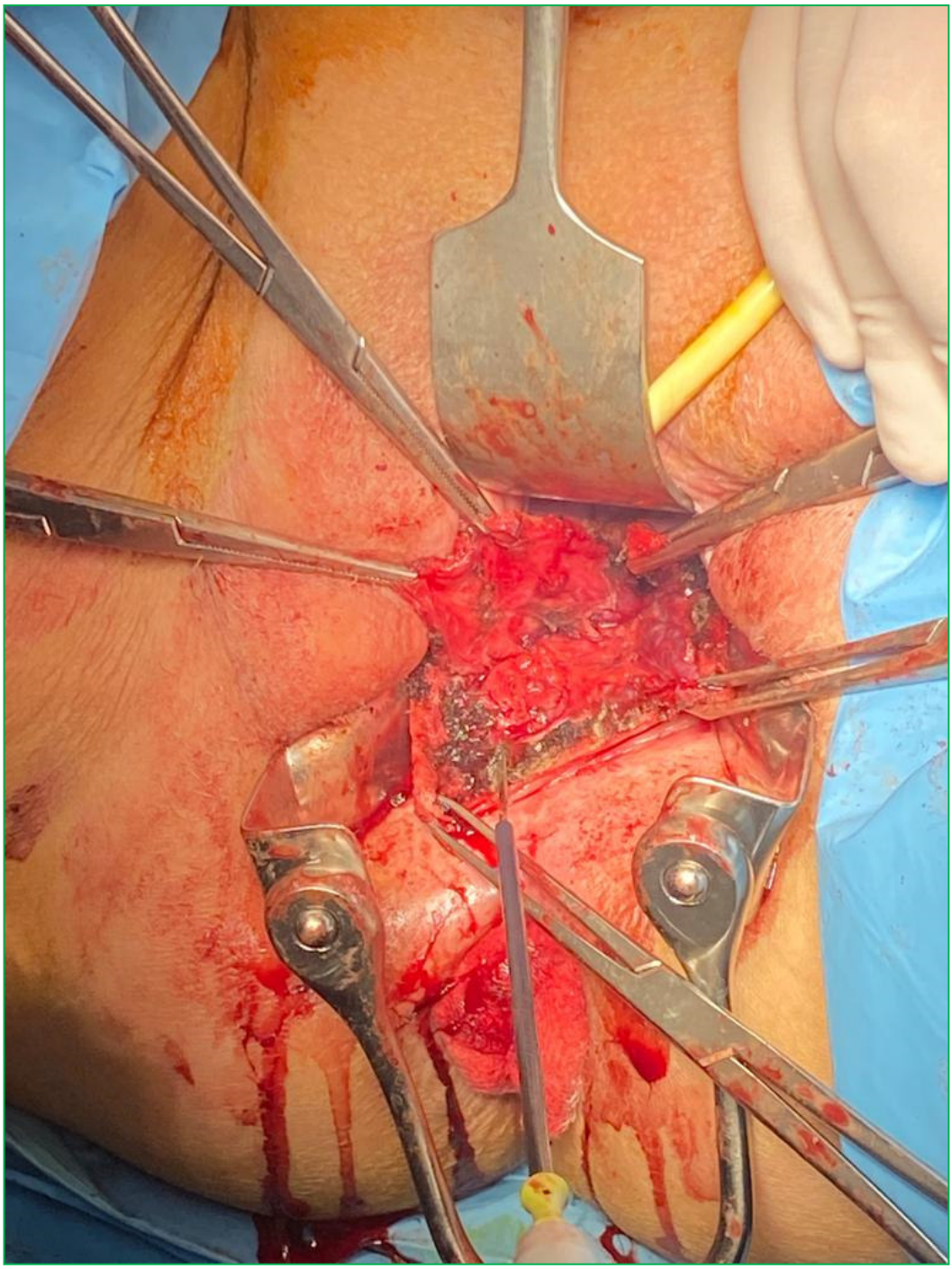

Figure 2. The posterior transvaginal approach. Clamps are holding the posterior vaginal wall.

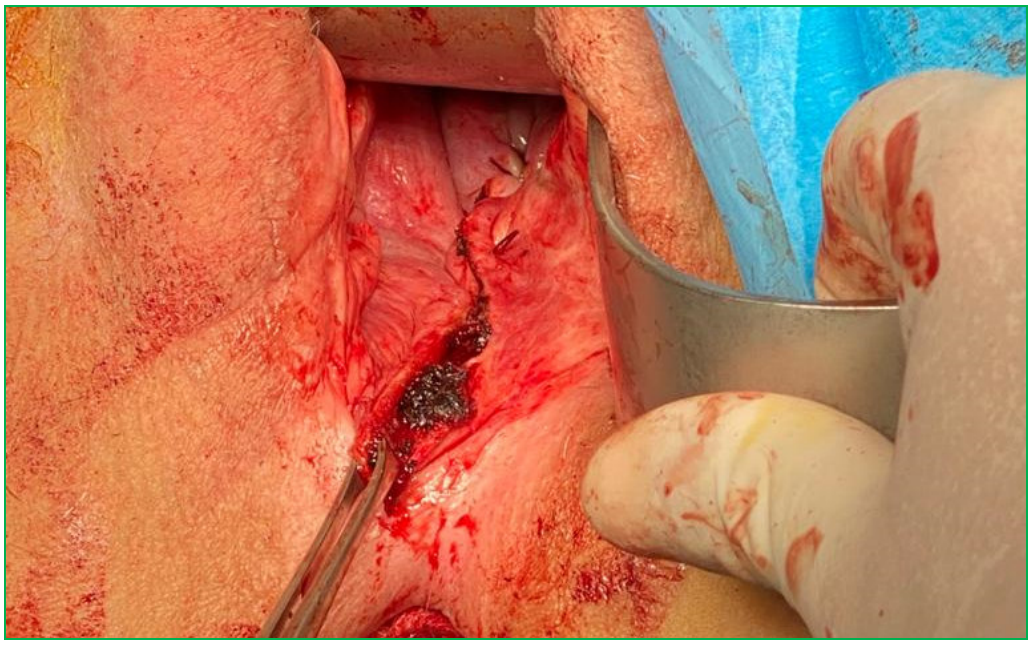

Figure 3. Plication of the rectovaginal septum. Redundant vaginal mucosa is excised.

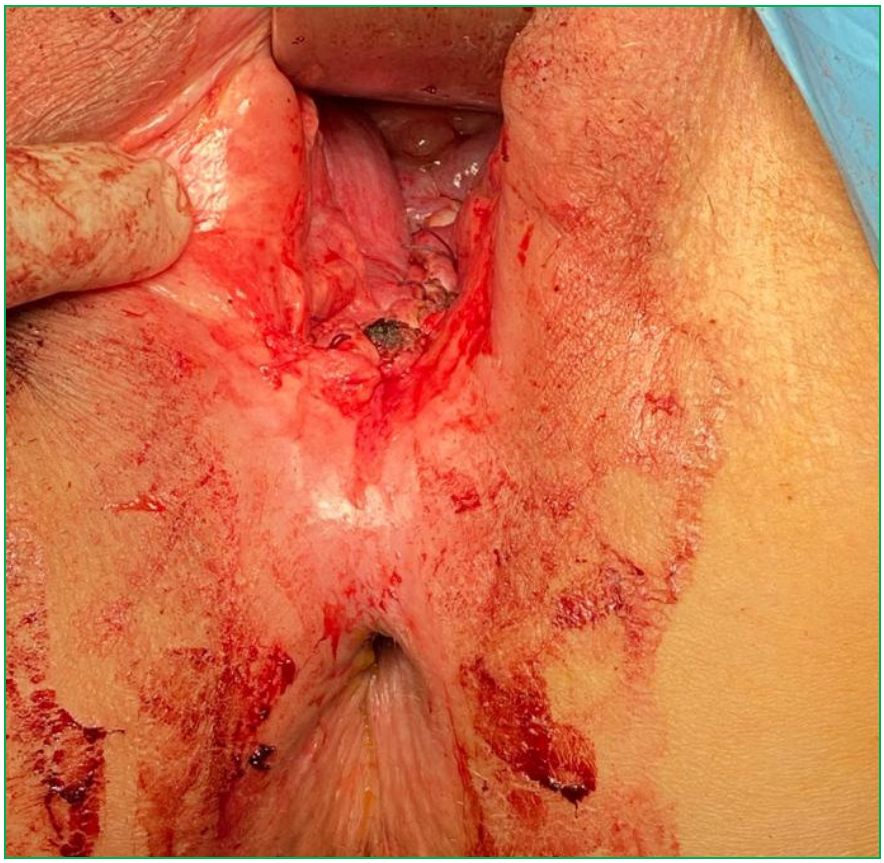

Figure 4. End result of the posterior colpo-perineorraphy.

3. Discussion

The initial treatment of rectocele starts with the modification of the risk factors and relief of obstructive defecation syndrome. Patients are prescribed osmotic laxatives along with dietary changes for more fibre intake.

Usage of pessaries, space occupying vaginal devices may be of help in select patients and it should be mentioned as a therapeutic alternative, though care must be taken to ensure proper usage as mucosal damage has been reported.

The patients with severe and symptomatic rectocele should undergo a surgical intervention. From the list of possible approaches, we can mention: a) posterior colporraphy with the reinforcing of the rectovaginal septum, with or without the placement of a reinforcing prosthetic mesh. Some studies report higer recurrence rates where mesh was applied; b) transanal plication; c) transanal resection; d) abdominal suspension. Ultimately each of the procedures comes with the associated risks.

4. Conclusion

To conclude, it is the decision of the surgeon to find the best surgical approach for the treatment of rectocele. Not only he should be comfortable with the procedure, but care should be taken to achieve the full relief of the symptoms of the patient.

For this specific case, due to the higher stage of rectocele, a posterior colporraphy, with the transvaginal plication of rectovaginal septum was chosen as a safe and efficient surgical approach.

Conflict of interest

The author(s) declare(s) that there is no conflict of interest. The authors alone are responsible for the content and writing of the paper.

Financial disclosure

There is no financial support to this study.

Ethical aspect

Informed consent was obtained from all participants in the study and all procedures were conducted in accordance with the Declaration of Helsinki.

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