

Editorial

Differences in the Diagnosis and Treatment of Rectocele: Time for Standardization

Diferenças no diagnóstico e tratamento da rectocele: é hora da padronização

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Female Pelvic and Reconstructive Surgery (FPRS) is a multi-disciplinary subspecialty that combines the efforts of different professionals to benefit women with pelvic floor disorders.¹ Gynecologists, urologists and colorectal surgeons are working simultaneously and trying to offer the best treatment to their patients. However, each medical specialty presents different backgrounds, and this leads to different points of view for approaching a disease whose treatment could (or should) be carried out in a collaborative fashion. This is particularly important when surgical treatment is indicated.

The posterior compartment of the female pelvic floor is an interesting and scarcely explored area, with divergent opinions about the best way to manage it. These differences are so present that the International Urogynecological Association (IUGA) and the International Continence Society (ICS) recently decided to make a joint report about Female Anorectal Dysfunction.²

Rectocele is a bulging of the rectum that protrudes to the posterior vaginal wall and corresponds to half of all prolapse surgeries performed in the US.³ Annually, 160,000 Pelvic Organ Prolapse (POP) surgeries are made in the US, and due to the aging population, there is a trend in the increase of number of procedures.⁴ Considering that rectocele is part of the posterior compartment, the reconstruction of this area is still one of the most difficult aspects of pelvic floor surgery,⁵ and its repair involves from simple plication to site-specific repair, as well as the use of synthetic and biological meshes.

The contribution of different specialties to the treatment of rectocele may have its peculiarities. However, these differences never have been investigated in depth. In a quick search on PubMed we were able to retrieve almost 1,200 abstracts using *rectocele* as keyword. However, only a single study addressing these differences was found. Surgeons and gynecologists have not reached a consensus regarding the nomenclature, diagnosis and treatment of rectocele.⁶

Colorectal surgeons refer to rectocele as the most prevalent clinical finding of the obstructive defecation syndrome (ODS), and it presents constipation, straining for defecation,

fecal urgency (sense of incomplete evacuation), tenesmus, pelvic heaviness and self-digitation.^{7,8} Although rectocele may be associated to ODS, most studies point out that it is rather a consequence than a cause of ODS.⁹

Moreover, most studies frequently investigate the association of rectocele with adjuvant anatomical abnormalities. One classic example is the link between rectocele and intussusception. About 67.5% of patients with clinical diagnosis of rectocele present an intussusception on magnetic resonance defecography.¹⁰ A study with postoperative protocols indicated that the anterior rectal wall intussusception would have the same etiology as a rectocele, that is, a deficient recto-vaginal ligamentous support.¹¹

Regarding diagnosis, colorectal surgeons usually classify rectocele by defecography, magnetic resonance imaging defecography, and endoanal ultrasonography, and the intensity of the symptoms may be scored by constipation degree or other anorectal symptoms. On the other hand, these professionals seldom or never use the Pelvic Organ Prolapse Quantification (POP-Q) classification.

Differently, gynecologists recognize rectocele as a clinical finding of pelvic organ prolapse (POP). No special importance is given to rectal examination and to the necessity for differential diagnosis with other anorectal disorders.⁵ It seems to us that gynecologists investigate these patients in a more superficial fashion. Women generally present to gynecologists with other symptoms that are more relevant to them, such as urinary incontinence, and gynecologists in general apparently underestimate the clinical manifestations of rectocele in comparison to colorectal surgeons. There are two important questions that rise from this issue: is the training in ob-gyn residency programs adequate enough for approaching FPRS? Is there an adequate academic formation in colorectal surgery in ob-gyn residency programs? Efforts must be done to improve these possible flaws in the ob-gyn resident training program.

However, there are points of convergence between specialists when the patient presents symptoms of the rectocele.

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Expectant management should be employed even though differences can be observed according to symptoms. Colorectal surgeons are more prone to prescribe treatment with fibers and biofeedback training for rectoceles with ODS.¹² On the other hand, gynecologists tend to add the use of pessaries for some severe associated prolapses.¹³

Divergences begin when surgical treatment is taken into consideration. Colorectal surgeons prefer the transanal approach, such as stapled transanal rectal resection (STARR) and laparoscopic ventral rectopexy. These are the most common choices for rectoceles that coexist with intussusception.^{7,14} A robotic approach has also been utilized with favorable short-term results when compared with the laparoscopic rectopexy.¹⁵ Rectoceles associated with internal rectal mucosal prolapse can be corrected by rectal prolapsectomy.¹⁶ A recent meta-analysis showed that STARR may reduce ODS symptoms; however, it seems that its effect is overestimated.¹⁷ Moreover, proctalgia, fecal urgency, and rectal bleeding are complications that can occur in patients who undergo to this procedure.

Gynecologists are more focused on the transvaginal approaches for simple rectoceles. A Cochrane review found that the posterior vaginal repair presents fewer current prolapse symptoms when compared with the transanal repair.¹⁸ The other advantages would be the broader exposure when compared with the transanal repair and the possibility of correcting other concomitant pelvic prolapses (such as cystocele or uterine prolapse), or other posterior defects (posterior colporrhaphy, perineorrhaphy and site-specific defect repair).⁵

Finally, the use of meshes lacks consensus. Most of the authors use it as a combined transanal-transperineal and abdominal approach. Synthetic meshes in the posterior compartment are not recommended by the specialized societies (International Urogynecological Association, Society of Gynecological Surgeons, American Urogynecological Association) and the US Food and Drug Administration (FDA) released a public health notification warning surgeons about possible complications.¹⁹

Despite FPRS being a multidisciplinary specialty, differences regarding the diagnosis and treatment of rectocele are seen between gynecologists and colorectal surgeons. Medical societies that diagnose and treat rectocele should come together in a joint effort to establish guidelines to standardize the approach of these patients, aiming to improve the diagnosis and treatment of rectocele. Both gynecologists and colorectal surgeons should gain more knowledge about anorectal disorders and transvaginal approaches for the surgical procedures. Multidisciplinary groups will enhance this proximity and improve patient care.

References

- 1 DeLancey JO. Current status of the subspecialty of female pelvic medicine and reconstructive surgery. *Am J Obstet Gynecol* 2010; 202(6):658.e1–658.e4
- 2 Sultan AH, Monga A, Lee J, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female anorectal dysfunction. *Neurourol Urodyn* 2016. DOI : 10.1007/s00192-016-3140-3
- 3 Shah AD, Kohli N, Rajan SS, Hoyte L. The age distribution, rates, and types of surgery for stress urinary incontinence in the USA. *Int Urogynecol J Pelvic Floor Dysfunct* 2008;19(1):89–96
- 4 Wu JM, Kawasaki A, Hundley AF, Dieter AA, Myers ER, Sung VW. Predicting the number of women who will undergo incontinence and prolapse surgery, 2010 to 2050. *Am J Obstet Gynecol* 2011; 205(3):230.e1–230.e5
- 5 Richardson ML, Elliot CS, Sokol ER. Posterior compartment prolapse: a urogynecology perspective. *Urol Clin North Am* 2012;39(3): 361–369
- 6 Huizinga CR, Deen-Molenaar CB, vander Mijnsbrugge GJ, van der Vaart CH. [Survey among gynaecologists and surgeons on rectocele]. *Ned Tijdschr Geneeskd* 2014;158:A7242Dutch.
- 7 Podzemny V, Pescatori LC, Pescatori M. Management of obstructed defecation. *World J Gastroenterol* 2015;21(4):1053–1060
- 8 Ellis CN, Essani R. Treatment of obstructed defecation. *Clin Colon Rectal Surg* 2012;25(1):24–33
- 9 Hicks CW, Weinstein M, Wakamatsu M, Pulliam S, Savitt L, Bordeianou L. Are rectoceles the cause or the result of obstructed defaecation syndrome? A prospective anorectal physiology study. *Colorectal Dis* 2013;15(8):993–999
- 10 Hausammann R, Steffen T, Weishaupt D, Beutner U, Hetzer FH. Rectocele and intussusception: is there any coherence in symptoms or additional pelvic floor disorders? *Tech Coloproctol* 2009; 13(1):17–25, discussion 25–26
- 11 Abendstein B, Petros PE, Richardson PA, Goeschken K, Dodero D. The surgical anatomy of rectocele and anterior rectal wall intussusception. *Int Urogynecol J Pelvic Floor Dysfunct* 2008;19(5): 705–710
- 12 Hicks CW, Weinstein M, Wakamatsu M, Savitt L, Pulliam S, Bordeianou L. In patients with rectoceles and obstructed defecation syndrome, surgery should be the option of last resort. *Surgery* 2014;155(4):659–667
- 13 Clemons JL, Aguilar VC, Tillinghast TA, Jackson ND, Myers DL. Patient satisfaction and changes in prolapse and urinary symptoms in women who were fitted successfully with a pessary for pelvic organ prolapse. *Am J Obstet Gynecol* 2004;190(4):1025–1029
- 14 Jones OM, Cunningham C, Lindsey I. The assessment and management of rectal prolapse, rectal intussusception, rectocoele, and enterocoele in adults. *BMJ* 2011;342:c7099
- 15 Wong MTC, Meurette G, Rigaud J, Regenet N, Lehur PA. Robotic versus laparoscopic rectopexy for complex rectocele: a prospective comparison of short-term outcomes. *Dis Colon Rectum* 2011; 54(3):342–346
- 16 Pescatori M, Quondamcarlo C. A new grading of rectal internal mucosal prolapse and its correlation with diagnosis and treatment. *Int J Colorectal Dis* 1999;14(4–5):245–249
- 17 Van Geluwe B, Stuto A, Da Pozzo F, et al. Relief of obstructed defecation syndrome after stapled transanal rectal resection (STARR): a meta-analysis. *Acta Chir Belg* 2014;114(3):189–197
- 18 Maher C, Feiner B, Baessler K, Schmid C. Surgical management of pelvic organ prolapse in women. *Cochrane Database Syst Rev* 2013;(4):CD004014
- 19 U.S. Food and Drug Administration. [Internet]. Update on serious complications associated with transvaginal placement of surgical mesh for pelvic organ prolapse. 2011 [cited 2015 Apr 21]. Available from: <http://www.fda.gov/medicaldevices/safety/alertsandnotices/ucm262435.htm>