

Ventral Rectopexy for Treatment of Rectocele: About 62 Patients

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Abstract

Disorders of the posterior pelvic floor are common. Their care is complex due to the diversity of symptoms and the frequency of their association.

Ventral rectopexy has known an important development and used in the treatment of rectal prolapse.

The purpose of this study was to report the experience of the ventral rectopexy for the treatment of rectocele and to evaluate the anatomical correction and the functional outcome.

Our study presents very satisfactory results. Indeed, with a long follow-up of 34.3 months, the morbidity is minimal and the anatomical correction with a low recurrence rate is satisfactory. Our overall satisfaction rate is also very good.

Keywords: Ventral rectopexy; Rectocele; Internal prolapse; Laparoscopy

Introduction

Disorders of the posterior pelvic floor are common. Their care is complex because of the diversity of symptoms and the frequency of their association. In the past decades, ventral rectopexy has known an important development due to the contribution of laparoscopy [1]. This technical, first used in the treatment of rectal prolapse is now extended to treat rectocele. The purpose of this study was to report the experience of the ventral rectopexy for the treatment of rectocele only with or without an intussusception and to evaluate the anatomical correction and the functional outcome.

Materials and Methods

We presented a retrospective study. Sixty-two patients were operated between January 2007 and November 2012 by ventral rectopexy to the promontory at the University Hospital of Caen. For each patient were collected age, body mass index (BMI), duration of hospitalization and complications, the follow up was completed by a quality of life questionnaire. This questionnaire is provided in appendix.

With regard to the surgery, only rectopexies using the technical of D'Hoore were selected. This technical described by D'Hoore and Penninckx [1,2] allows minimal rectum mobilization. The rectovaginal septum is opened without dissection of the lateral and posterior surfaces of the rectum. One prosthesis is placed on the ventral position of the rectum and anchored by one or two points to the promontory without traction.

With regard to the follow up, control consultation is provided between one and two months, then between four to six months. Moreover, a questionnaire was sent retrospectively to all patients within six months from six years after the surgery (questionnaire in

Appendix). The main interest is to evaluate the impact of their illness and surgery on their quality of life. This questionnaire from the ODS Score aims to assess the obstructed defaecation, the presence of pain or pelvic heaviness and the social impact. We added to the questionnaire more overall items such as before and after surgery feeling and the degree of satisfaction.

Outcomes

All the patients were female. The patient average age at surgery was 61.4 years with a range from 36 years to 82 years.

This study includes only patients with a rectocele. It is noted that fifteen of them (24%) presented combined internal prolapse.

The average follow-up was 34.3 months, with extremes ranging from 7 months to 76 months.

The most common symptom observed in our series is obstructed defaecation. This symptom is noted in the medical examination for fifty patients (81%), combined with digital facilitation for thirty-one patients (50%). Over twenty-six patients (42%) suffered of pelvic heaviness and fifteen patients (24%) of vaginal bowls. In the interview, eleven patients (18%) suffered of fecal incontinence.

Majority of the patients were operated by laparoscopy (52 patients or 84%), five of them (8%) required a conversion and ten (16%) were initially operated by laparotomy because of their surgical history.

There was no perioperative mortality. Early postoperative morbidity occurs during hospitalization. One patient had an early complication: acute cystitis responding positively to antibiotics. We noted four late complications except recurrences (6.5%): a small-bowel occlusion due to adhesion, a trocar hernia four months later and two fecal incontinence controlled with sacral neuromodulation.

Four recurrences (6.5%) occurred within an average period of 7 months, with a range from 1 month to 19 months. For three of them,

recurrence of rectocele occurred below the prosthesis. For the latter, there was adisinsertion of the prosthesis from the promontory.

The ODS score questionnaire form was sent to sixty-two patients. Fifty-eight patients (94%) returned the completed questionnaire. For the four other patients, there is one death and three are lost sight.

We retrospectively analysed each symptom to assess their improvement or worsening.

The results for obstructed defaecation are presented in Table 1. No patient had obstructed defaecation de novo or felt worsened after surgery. Twenty patients had fewer than three stools per week (34.5%). Among them, fourteen patients feel currently improved with a stool per day or every other day (70% improvement). Thirty-two patients were using digital facilitation (55% of patients). Before surgery, twenty-five patients (i.e. 78%) do not use this digital facilitation after surgery. Forty-three patients (74%) had either evacuation difficulties or feelings of incomplete evacuation. For thirty of them, this symptom has disappeared (70% of success).

	Stools <3 per week	Digital facilitation	evacuation difficulties or incomplete evacuation
Asymptomatic patients before and after surgery	38	26	15
Symptomatic patients before surgery	20	32	43
improved	14	25	30
identical	6	7	13
aggravated	0	0	0
De novo symptomatic patients	0	0	0

Table 1: Incidence of obstructed defaecation before and after surgery. In this table, we retrospectively analysed each symptom, before and after surgery, to assess their improvement or worsening.

The evolution of pain or pelvic heaviness was also studied. No de novo or worsening pain appeared after surgery. More than half of patients (thirty-eight patients) presented pain or pelvic heaviness before surgery. In 71% of cases (twenty-seven patients), the discomfort has completely disappeared. For eleven of them (29%), the painful symptomatology remained unchanged.

The ODS score also helps us to know the impact of the disease and surgery on patients' activities. Twenty-seven patients (46.5%) had no impact from their pathology in their activity and do none had after surgery. For thirty-one patients who experienced a reduction in their activity due to their pathology (53%), 87% feel improved after surgery, allowing recovery. No patient was worse on this item.

The impact of disease on their social life is also an important consideration in the assessment of the functional outcome of this surgery. Thus we have included to our questionnaire an item to assess the impact on social life. For thirty-six patients (58%), the surgery has reduced the discomfort in social life. For twelve patients, the surgery did not decrease the inconvenience and for four of them the social impact remained important.

Patients could choose between five items (totally disappeared, little or much improved, unchanged, worsened) to assess the overall outcome of surgery. Fifty patients (86%) are improved. For eight of them, there was no change in their clinical condition. None of them felt worse.

Finally, we asked patients if they would accept to be operated again using the same technical. Thirty-nine patients (67%) agreed. Ten patients (17%) would refuse. And for the rest of the sample (nine patients) the answer is uncertain.

Discussion

Literature is dense about the short and medium term of the ventral rectopexy for rectal prolapse since 2006. It is much less for rectocele and in this case the mean follow-up is short and the number of patients is reduced.

Wong [3] reports a loss of obstructed defaecation for 50% of his patients in a series of eighty-four patients over four years. Moreover, there are few studies relating the long term quality of life for patients operated for rectocele by rectopexy [4].

A study [5] is published in August 2013 about thirty patients considering only the evolution of obstructed defaecation with a follow-up of forty-two months.

Our study had a follow-up of 34.3 months, and took into account obstructed defaecation, pelvic pain, digital facilitation, social satisfaction and overall impact. The obstructed defaecation were improved for 70% of patients and for 78% of them, there is no more digital facilitation. It should also be noted that no patient has been worsened by our surgery. Although this study was retrospective, it had the advantage to consider only the patients operated for a rectocele and with a significant follow-up.

We also examined whether there was a relation between the number and severity of symptoms experienced and the level of satisfaction. Three symptoms that occur most often during consultations (obstructed defaecation, digital facilitation and pelvic heaviness or pain) were identified and compared to the level of patient satisfaction (completely or significantly improved, slightly improved, not improved). So when patients had three symptoms or two symptoms daily, there was a complete release of symptoms or significant improvement in 60% of the population. This rate downed to 25% when the patient had only one symptom. On the other side, when patients experienced fecal incontinence, regardless of the number of associated symptoms, they were totally or significantly improved in 66% of cases.

Finally, our overall satisfaction (totally, significantly or slightly improved) on all patients was 86% regardless of the significance or number of symptoms. It may be noted that for patients with three symptoms or two with daily incidence, this overall satisfaction rate increased to 88%. And for patients with fecal incontinence, this rate was 100%.

All of these results emphasize that the overall satisfaction of patients is obviously better when their symptoms before surgery were significant or considered as incapacitating. We must therefore keep in mind that there is no correlation between the severity of anatomical abnormalities and symptomatology.

Thus, it is necessary to determine the significance of functional discomfort before proposing surgery.

Conclusion

The ventral rectopexy according to D'Hoore for the treatment of rectocele appears as a technical reference.

Indeed, the literature and our study show a minimal morbidity, a satisfactory anatomical correction with a low recurrence rate. Moreover, considering the long-term functional outcome, the most important objective is satisfactory. Our overall satisfaction rate is 86%.

At last, the use of standardized questionnaire is absolutely necessary in order to objectively assess the feelings of patients and to better adapt our care.

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