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TRANSVAGINAL CADAVERIC FASCIA LATA REPAIR OF RECTOCELE (CAR PROCEDURE): THREE-YEAR PROSPECTIVE FOLLOW-UP

Hypothesis / aims of study

To present our experience with rectocele repair (CaR procedure) using non-frozen cadaveric fasica lata.

Study design, materials and methods

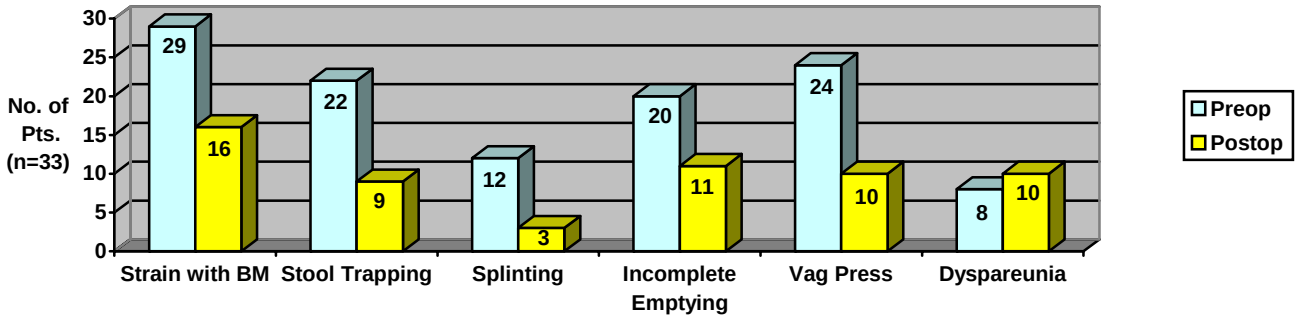
33 women, ages 31-86 (mean 61 years) had the CaR procedure with a maximum follow up of 37 months (range 6-37 months, mean 16 months). A 4 X 7 cm piece of non-frozen cadaveric fascia lata is placed transvaginally to repair the rectocele. The fascial patch is secured, without tension, to the levator muscles bilaterally, the vaginal cuff or cervix at the apex, and to the perineal body distally. Standard perineorrhaphy is performed in addition to CaR in those with excessive perineal laxity, or those desiring a decrease in introital diameter. Pelvic exam and questionnaires were administered every 6-12 months to evaluate outcomes.

Results

All patients had Baden-Walker grade 2-4, symptomatic rectoceles preoperatively. Eight patients underwent CaR procedure alone, while 25 patients had CaR plus cadaveric cystocele repair and/or vaginal vault suspension. Ten patients underwent periniorrhaphy. Five patients had previous rectocele repairs (5/33, 15%).

91% (30/33) of patients had no recurrent rectocele by exam. Of the 3 recurrences, one was grade 1 and asymptomatic, making the symptomatic rectocele recurrence rate 6% (2/33).

Questionnaire outcomes dealt with three areas of symptomatology: Bowel function, prolapse symptoms (vaginal pressure), and sexual function. The results are as follows;



With respect to overall bowel function, 24% (8/33) stated that their bowel function continued to be problematic, while 58% (19/33) stated that their bowel function was significantly improved.

Twenty-two patients (67%) were sexually active. Postoperatively, overall sexual function improved in 7/22 (32%), worsened in 5/22 (23%), and was unchanged in 10/22 (45%). De novo dyspareunia developed in 2/22 (9%), both patients had periniorrhaphy. 27/33 (82%) of patients were $\geq$ 70% satisfied with the results of the repair, and 28/33 (85%) stated that they would have the surgery again. Other than the 2 patients (9%) with de novo dyspareunia, there are no complications to report.

Interpretation of results

With an average follow-up of 16 months, the symptomatic rectocele recurrence rate following the CaR procedure is excellent at 6% (2/33). This compares favorably to previous series of traditional posterior colporrhaphy and defect-specific posterior repairs in which rectocele recurrence has been reported as high as 18-35% [1-3]. By repairing the entire vaginal floor with a strong allograft, the dependence upon identifying a discrete defect and obliterating it by reapproximating inherently weak tissue under tension is avoided. Additionally, there is minimal vaginal narrowing which accounts for the low incidence of de novo dyspareunia.

We have been able to show improvement in bowel and prolapse symptoms following the CaR procedure, as evidenced by > 50% decrease in the symptoms of stool trapping, splinting, and vaginal pressure. There were more women who stated that their overall sexual function was enhanced following the CaR procedure than women who stated that their overall sexual function worsened.

Concluding message

Our anatomic results performing transvaginal rectocele repair with non-frozen cadaveric fascia lata are excellent. Bowel function and vaginal pressure symptoms are improved, while de novo sexual dysfunction is minimal and may be associated with concurrent periniorrhaphy.

References

1) Posterior colporrhaphy: its effects on bowel and sexual function. Br L Obstet Gynecol, 104:82, 1997.
2) An anatomic and functional assessment of the discrete defect rectocele repair. Am J Obstet Gynecol, 179: 1451, 1998.
3) The anatomic and functional outcomes of the defect-specific rectocele repairs. Am J Obstet Gynecol, 181(6): 1353, 1999.