

POSTERIOR TRANSISCHIORECTAL POLYPROPYLENE MESH INTERPOSITION FOR RECTOCELE REPAIR IN WOMEN WITH RECURRENT SYMPTOMATIC RECTOCELE STAGE III OR IV

Hypothesis / aims of study

The reconstruction of a recurrence of rectocele using endogenous fascial tissue is unsatisfied, since it has been failed in the primary situation, endopelvic fascia is often not representing during the surgery, and stenosis of the middle vagina may be occurring. The abdominal reconstruction using mesh interposition (sacropexy) is a safe but largescale technique.

The video demonstrates the vaginal way for rectocele repair in women with recurrent symptomatic rectocele stage IV using posterior transischiorectal polypropylene mesh interposition.

Study design, materials and methods

35 women (mean age 64.6 ± 25 years) with recurrence of rectocele (AP, BP Stage III / VI, POPQ) were treated by above mentioned surgery technique and clinical evaluated in a 2 month follow up. For tissue replacement a monophile propylene mesh (Apogee®) with two by plastic sheets covered mesh arms (Company: American Medical Systems) were used. The steps of surgery are:

Preparation of rectocele; repair of the rectocele by fascial reconstruction; renewed perianal disinfection; mobilization of the pararectal space on both sides; transischiorectal introduction of the needles; piercing of the ileococcygeus muscle at the point of attachment of the ischial spine; fixation of the mesh to the vaginal cuff; reposition of the vaginal cuff to its original position by means of fine adjustment of the limbs of the mesh; shortening of the limbs of the mesh to the level of the skin; and closing the vaginal skin.

Results

No forced intraoperative bleeding and no injury of the rectum were documented, one postoperative haematoma (2.8 %) objectified by ultrasound behind the mesh and anterior rectal wall (4 x 5 cm) without influence of the bowel function has been seen, no revision has been necessary. Infections and mesh rejections were not seen, by 2 women (5.7 %) a defect healing with partial mesh erosion were documented and resolved by mesh trimming and over-suturing. No stenosis of the vagina, recurrence of prolapse, and nerve irritation were seen.

Interpretation of results

The demonstrated operation technique can be performed standardized alone or in combination with supplementary vaginal reconstructive techniques. It is a less traumatic technique, which takes care of the recurrent situation. The rate of mesh erosions is comparable to other published series describing prosthetic mesh repairs.

Concluding message

Long term follow up is necessary to assess the functional and morphologic results of the demonstrated technique.