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PREVENTION RECURRENCE AND INCREASING THE EFFECTIVENESS OF SURGICAL CORRECTION OF THE RECTOCELE

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Abstract. The problem of prolapse and prolapse of the internal genitalia in women has remained relevant for many years. In almost all cases, patients with OIVVD have functional disorders of the pelvic organs, the so-called complicated form of OIVPO, characterized by the involvement of the bladder and intestines in the process. Rectocele is a pathological condition that is etiologically and pathogenetically associated with pelvic organ prolapse. Proctologists define a rectocele as a diverticulum-like protrusion of the anterior wall of the rectum towards the vagina [1], and in gynecological literature, this term refers only to the prolapse or prolapse of the posterior vaginal wall [2]. The clinical picture of rectocele in OIVVPO consists of several groups of symptoms: symptoms of impaired motor-evacuation function of the colon, symptoms of genital prolapse, sexual dysfunction. The main signs characterizing rectal dysfunction are the symptoms of obstructive defecation: prolonged constipation, the need to use a finger aid (transvaginal, transrectal or perineal) in order to eliminate the prolabrating anterior wall of the rectum and facilitate its emptying. The patient has to strain for a long time with the active involvement of the abdominal press, patients are bothered by frequent and ineffective urges to defecate, a feeling of discomfort with downward pressure.[5] Disruption of the fecal evacuation process is accompanied by inflammatory changes in the distal parts of the colon and the occurrence of concomitant proctological diseases. This is manifested by the discharge of blood from the anus, prolapse of internal hemorrhoids, flatulence, and pain during defecation [1, 7]. For the treatment of rectocele, many conservative therapy regimens are used aimed at normalizing the stool and strengthening the pelvic floor muscles, but the main method of treatment remains surgical.[3,4] Traditional reconstructive plastic surgery on the pelvic floor is aimed at eliminating the diverticulum-like protrusion of the anterior wall of the rectum into the vagina and strengthening the rectovaginal septum.

Key words: Rectocele; pelvic organ prolapse; evacuation dysfunction of the rectum; 3-D ultrasound of the pelvic floor.

Evaluation of the efficacy of retroperitoneal vaginal colpopexy using the Prolift prolene system for the treatment of rectocele in women who were evaluated using a specific diagnostic algorithm.

Study Inclusion Criteria:

• rectocele of the 2nd-3rd degree in stage II-IV prolapse of the posterior vaginal wall;

• recurrence of rectocele after traditional pelvic floor surgeries. Study exclusion criteria:

• An OIVPO uncomplicated by the presence of a rectocele;

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• patients with polyvalent allergy due to the high risk of developing a rejection reaction of synthetic material. Examination before and after surgery, as well as surgical treatment of patients.

Materials and methods.

When interviewing patients for objectification of complaints, quantitative interpretation of symptoms of intestinal dysfunction and control of the effectiveness of the treatment, a scoring system was used to assess the degree of disorders of the evacuation function of the colon: 1st degree rectocele is defined as a small pocket of the anterior wall of the rectum only by finger examination of it; Stage 2 – protrusion of the rectal wall is detected when the labia are spread apart and when the patient strains. The stretched anterior wall of the rectum reaches the level of the external sphincter of the anus or the vestibule of the vagina. 3rd degree – characterized by protrusion of the anterior wall of the rectum beyond the genital fissure and anal pulp when straining and/or at rest. The data of the objective examination were supplemented by instrumental examination of the patients, which included 3-D ultrasound of the pelvic floor and evacuation X-ray proctography. Ultrasound examination of each patient was carried out on the Voluson-730 expert (GE) device with a vaginal probe with a frequency of 6.5 MHz, located in the vaginal vestibule, in the position of the patient lying on her back with a full bladder. In cross-section, the anal sphincter and the adjacent structures of the pelvic floor triangle were evaluated: the tendon center of the perineum, the muscle bundles of the levators, and ultrasound signs of pelvic floor muscle insufficiency were revealed. In the sagittal section, the presence of a rectocele at rest and during straining was diagnosed, in the postoperative period, the location of implants in the pelvic cavity and the position of the lower edge were assessed. The analysis of the data obtained was carried out using the SPSS statistical software package. The significance of the differences in the tables was assessed using the chi-square test and the exact one-sided Fisher test. Quantitative indicators were compared using nonparametric sign tests and Wilcoxon (for related samples) and Wald-Wolfowitz and Mann-Whitney (for independent samples). Estimates of correlation coefficients for quantitative and ordinal indicators were performed according to Spearman. To assess the impact of various risk factors on the likelihood of relapse, a step-by-step logistic regression procedure was applied. The difference at p<R is moderate, R>0.65=7 is a strong correlation

Results of the study

The study involved 82 patients aged 37–77 years, the average average age of the examined was 58.0±3.2 years. The duration of OIVVO in patients of the 1st group took a time interval from 2 to 20 years, the median was 6 years. At the same time, a worsening of the course of the disease with the onset of menopause was noted in 26 (42.0%) patients, which indicates a negative impact of estrogen deficiency on the anatomical and functional state of the pelvic ligamentous apparatus and the mucous membrane of the urogenital tract. When analyzing the questionnaire reflecting the violation of the motor-evacuation function of the large intestine, it was revealed that almost all patients with rectocele in the 1st group complained of difficulties in defecation, a feeling of incomplete emptying of the rectum. At the same time, 60.0% of patients used a finger aid during defecation, which was performed by pressing on the perineum, the back wall of the vagina or the gluteal region. Tables 2 and 3 present the main manifestations and severity of motor-evacuation dysfunction of the rectum

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in the examined patients with rectocele before and after surgical treatment. After surgical treatment, there was a statistically significant improvement in the motor-evacuation function of the rectum in patients with rectocele. Clinical examination data (stages of prolapse of the posterior vaginal wall (point Bp) by POP-Q and rectocele degree) in patients with OIVVPO and rectocele are shown in Tables 4 and 5. Thus, clinically "excellent" anatomical results after surgical treatment of rectocele were achieved in 55 (88.8%) patients (absence of rectocele), and "excellent" results of PTO correction were obtained in 51 (81.3%) patients (prolapse of the posterior vaginal wall 0 according to POP-Q). "Good" results of rectocele treatment (grade 1 rectocele) were noted in 4 (6.4%) patients, as well as a "good" result of correction of prolapse of the posterior vaginal wall (stage I or stage II in the presence of stage III–IV before surgery) was obtained in 8 (12.9%) patients. Recurrence of rectocele of the 3rd degree, i.e. an "unsatisfactory" result in combination with prolapse of the posterior vaginal wall of stage III, was noted in 3 (4.8%) women.

Discussion of the results of the study

Analyzing the results of surgical treatment of rectocele with retroperitoneal vaginal colpopexy using the Prolift system, it is necessary to note the fairly high anatomical and functional effectiveness of this method of treatment. In our study, the restoration of normal anatomical relationships between the rectum and the structures of the pelvic floor was achieved in 95.2% of cases, and the improvement of rectal function was achieved in 95.1% of cases. The use of a scoring system for the severity of motor-evacuation dysfunction of the rectum was necessary to assess the severity of intestinal dysfunction, prescribe conservative therapy before and after surgical treatment, and assess the anatomical and functional result of treatment.[6]

References

1. Dynamic transperineal ultrasound vs. defecography in patients with evacuatory difficulty: a pilot study / BeerGabel M. // Int. J. Colorectal. Dis. — 2004. — Vol. 19. — P. 60–67.
2. Kahn M. A., Stanton S. L. Posterior colporrhaphy: its effects on bowel and sexual function // Br. J. Obstet. Gynaecol. — 1997. — Vol.104. — P.82–86.
3. Karasick S., Karasick D., Karasick S. R. Functional disorders of the anus and rectum: findings on defecography/ // AJR. — 1993. — Vol.160. — P.776–782.
4. Piloni V. L., Spazzafumo L. Sonography of the female pelvic floor: clinical indications and techniques // Pelviperineology. — 2007. — Vol.26. — P.59–65.
5. The reliability of puborectalis muscle measurements with 3-dimensional ultrasound imaging / Weinstein M. M. [et al.] // Am. J. Obstet. Gynecol. — 2007. — Vol.197. — P.68. e1–6.
6. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction / Bump R. C. [et al.] // Am. J. Obstet. Gynecol. — 1996. — Vol.175, N1. — P.10–17.
Transanal or vaginal approach to rectocele repair: results of a prospective randomised study / Nieminen K. [et al.] // Neurourol. Urodyn. — 2003. — Vol.22. — P.547–548.