Tears, Not Deterioration, Said to Cause Rectoceles

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Contributing Writer

SANTE FE, N.M. — Many physicians need to unlearn what they were taught about rectoceles, according to Marvin H. Terry Grody, M.D., of Robert Wood Johnson Medical School at Camden (N.J .).

Tears in the connective tissue of the rectovaginal septum cause these defects—neither attenuation nor deterioration is responsible, he said at a conference on gynecologic surgery sponsored by Omnia Education.

"We've all been trained in the traditional method that searches around for scraps of tissue to bring together in the hopes that we can eliminate the rectocele. That's what we all have been doing for 200 years, and it's wrong," Dr. Grody said.

Some medical school professors still describe tears as uncommon, holding to the historic explanation of rectoceles as starting with the stretching of tissue in vaginal delivery, according to Dr. Grody. Usually childbirth does play an instigating role. He credited A. Cullen Richardson, M.D., with conclusively demonstrating over the last 2 decades of the 20th century that rectoceles most often stem from trauma caused by the descending vertex in vaginal delivery.

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"How come we didn't know about this before?" Dr. Grody asked rhetorically. "Well, we never bothered looking for them because we assumed attrition—deterioration—caused the defects. We didn't think tears."

Transverse tears—"either detachment from below adjacent to the perineal body or separation at the top in juxtaposition to the fibrous uterosacral extensions in the area of the cul-de-sac"—are the most frequent cause of rectoceles, he said. U-shaped tears at the bottom or top of the posterior pelvic compartment are also common.

Lesions shaped like a hockey stick may also be seen. These combine a longitudinal tear and a transverse tear. Less common, Dr. Grody said, is a double defect in which the Denonvilliers' fascia is torn in the perineal area and adjacent to the vault. Even stellate tears might have to be puzzled together.

Physicians should not assume the tear responsible for a rectocele will have a common shape. "It doesn't make a difference what statistics tell you in percentages of occurrence," he said. "That patient is one hundred percent of one, and she will have a lesion that is peculiar to her. Simply go find it, and put it together."

As outlined by Dr. Grody, the procedure is easier than the "traditional archaic repair." The physician places a finger in the rectum to find the defect and search for torn edges. "I guarantee you in 19 out of 20 cases you are going to find them—either up above or down below or on the side," he said.

Once the torn edges are located, he recommended sewing them together with interrupted monofilament sutures. "You cannot sterilize the vagina, and monofilament sutures resist infection far better than do braided or polyfilament sutures, very simply because bacteria cannot hide in monofilament sutures," he said.

After the breaks are repaired, the physician should place a finger in the rectum again.

"Where it could come well forward [before] because there was no resistance, you now cannot do it," Dr. Grody said. "The rectovaginal septum is restored to its natural configuration, and you can't poke your finger through it." ■

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