PATIENT INFORMATION

What is a rectocoele?

In women, a rectocoele is a bulge in the front wall of the rectum that pushes into the back wall of the vagina. The rectum and vagina are normally separated by a strong sheet of fibrous tissue known as the “rectovaginal septum”. This sheet of tissue can become thin and weak over time, resulting in a rectocoele. A rectocoele may occur by itself or be part of a general weakening of the pelvic floor muscles. Other pelvic organs, including the bladder (cystocoele) and small intestine (enterocoele), may also bulge into the vagina, causing similar symptoms.

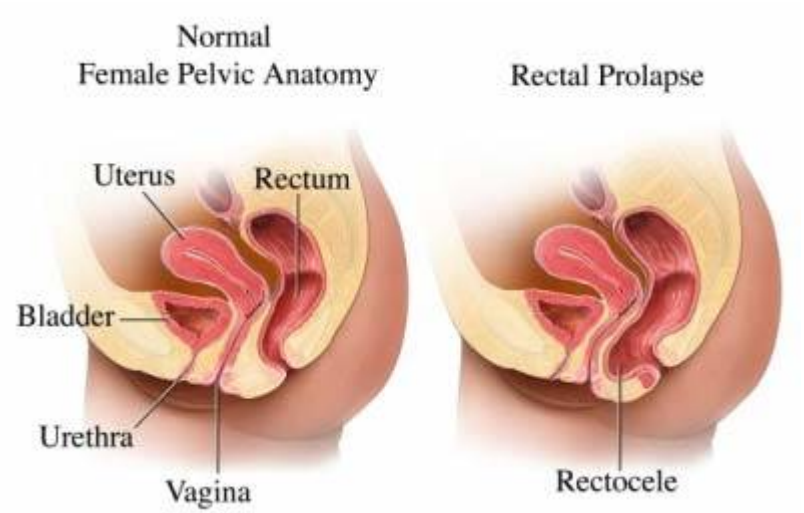

Figure. *Diagram of a rectocoele in women*

What causes a rectocoele?

Exactly what causes a rectocoele is not known. However, it is known that in women they often occur at the same time as weakening of the pelvic floor as part of becoming older and after menopause, multiple vaginal births, use of forceps, and tearing with a vaginal delivery. Chronic constipation and excessive straining with bowel movements are

thought to play a role. Multiple gynaecological operations can also lead to weakening of the pelvic floor and a rectocoele.

What are the symptoms?

Most women have no symptoms when a rectocoele is small. About 4 in 10 of all women will have a rectocoele found when they are having a routine examination. When symptoms are present, they may be rectal or vaginal. Rectal symptoms include difficulty emptying the rectum and the need to press against the back wall of the vagina and/or space between the rectum and vagina (the perineum) in order to have a bowel movement. Vaginal symptoms can include a sensation of a bulge or fullness in the vagina, tissue protruding out of the vagina, discomfort during sexual intercourse, and vaginal bleeding.

Symptomatic rectocoeles can lead to excessive straining on the toilet, the urge to have multiple bowel movements throughout the day, and rectal discomfort. Faecal incontinence or smearing may occur when small pieces of stool are retained in a rectocoele (known as “stool trapping”) and then seep out of the anus later on. Stool trapping can increase the sense of needing to have a bowel movement because the stool trapped in the rectocoele returns to the rectum when the patient stands up, producing a further urge to have a bowel movement.

How is a rectocoele diagnosed?

Your doctor will perform a pelvic examination that includes both the vagina and rectum. An instrument called a speculum is used to look inside the vagina. An examination of the rectum will usually find a weakness in the anterior wall of the rectum if a rectocoele is present.

A special X-ray, called a “defaecating proctogram”, may be used to look at how the bowel moves during the passing of a bowel motion. For this examination, a small amount of barium (a white chalky substance that shows up on X-rays) is put into the rectum, vagina, and bladder. X-rays are then taken with the barium inside your bowel. You will need to hold on to the barium while these are taken. You will then be asked to sit on a special chair in the X-ray room and let the barium go when you are told to. More X-rays are taken at the moment you pass the barium. This test tells the doctor how your bowel is working, and can show a rectocoele and its size. A rectocoele is thought to be a problem if it is larger than 2 cm and contains a lot of barium.

Can a rectocoele be treated?

A rectocoele would only be treated if you are having symptoms that interfere with your quality of life.

Non-surgical treatment

Many symptoms of a rectocoele can be managed effectively without surgery. It is very important to avoid constipation and straining with bowel movements. A high-fibre diet and drinking plenty of water will produce softer,

bulkier stools that do not require straining when moving your bowels. This will decrease your risk of symptoms. If you do not have the urge to have a bowel movement, do not force one, and avoid sitting on the toilet for long periods at a time.

Sometimes we use a treatment called biofeedback. This includes sessions with a specialist nurse who will help find ways to improve your bowel emptying. Biofeedback aims to strengthen and retrain the pelvic floor and can lessen the symptoms of a rectocoele.

Surgical treatment

Surgery will only be performed if you have symptoms that interfere with your day-to-day activities and do not go away. Colorectal surgeons, gynaecologists, and urogynaecologists are all trained in the diagnosis and treatment of rectocoeles, but may vary in the ways they treat them. The surgical treatment may be local or abdominal.

Local approaches include transanal repair (through the anus), perineal repair (through the space between the anus and vagina), and vaginal repair (through the vagina). Operations to repair the rectocoele aim to remove the extra tissue that makes up the rectocoele (the bulge) and to reinforce the rectovaginal septum (the tissue between the rectum and the vagina). This can usually be done by stitching the tissue together with dissolvable stitches. Occasionally, a "surgical mesh" can be used to strengthen the repair. Your surgeon will talk to you about the benefits and risks of using surgical mesh. Sometimes, part of the wall of the rectum is removed and the remnants are then joined back together using a small stapler placed through the anus. This operation is called a STARR ("stapled transanal rectal resection") procedure.

An *abdominal* approach may be used to repair an enterocoele if there is a significant internal rectal prolapse or if there is another prolapse present elsewhere in the pelvis, such as a prolapse of the uterus. This operation is called a rectopexy and can be performed by laparoscopic ("key-hole") surgery or through a longer cut in your abdomen (open surgery).

Will the repair of my rectocoele be successful?

The overall success of the surgery depends on the symptoms, length of time that the symptoms have been present, and the approach used for surgery. The risks include bleeding and infection (as with many surgical procedures), as well as pain during sexual intercourse that was not felt before, faecal incontinence (leaking from the rectum), a rectovaginal fistula (formation of an abnormal connection between the rectum and vagina), and recurrence or worsening of the rectocoele.

Some studies have found significant improvement in up to 9 out of 10 patients after surgery for a rectocoele. However, the success rate seems to decrease over time, and the rectocoele may recur at some time in the future. Your surgeon will be familiar with the repairs and options available, and will discuss the different approaches with you.

For more specific information on preparation and recovery from a rectocoele repair, please see LINK.

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