Colporrhaphy posterior

- **Operation Concept:**
  - Unification of the lateral supportive tissue (perineal body) to sink a rectocele to stabilize the pelvic floor by connecting the diverged levator muscels with sutures.

- **Indication**
  - Defect in the posterior wall of the vagina (protrusion of the rectum into the vagina=rectocele)

- **Contraindicaton**
  - Common Contraindications for an operation

- **Pre-operative Information for the patient:**
  - Risk of a rectum lesion
  - Painful sexual intercourse
  - Success rate 71-86% (for the first operation)

- **Operation planning:**
  - Gynaecological examination with vaginal- and introitus-ultrasound
  - Rectal examination: Sphinctertonus weak-> Sphinctertonometry
  - Dynamic pelvicography (Defaecography) when symptoms of a obstructive defecation disorder
  - Local application of oestrogen for four weeks prior operation, such as Ovestin Ovula 1x1
  - Perioperative antibiotic prophylaxis

- **Positioning of patient and cover:**
  Positioning oft he patient in lithotomy position (dorsosacral position). Disinfection of the genital area up to the lower abdomen and emptying of the bladder with single-use catheter.

Operation technique

- Take the posterior commissur at 5 and 7 o´clock with two bullet forceps and pull them caudal. No resection of vaginal or perineal skin (Coitus complaints possible). De-epithelialization of the posterior commissure for about 1cm.
- Dissection of the vaginal wall. Undermine the vaginal wall from the underlying tissues and cut the lower vaginal wall lengthwise. Grab the edges of the wound with Allis-clamps and stretch it. Dissect the vaginal wall sharp until you see the levators.
- Preparation of the rectum. Open the spatium rectovaginale bluntly cranial so that you can separate the rectum from the vaginal wall until the end of the vagina. Its important to separate the rectum laterally too, so you can see the connective tissue next to the rectum(Paraproktium). More caudally (at the lower vaginal third) mobilize the rectum lateral of the vagina with scissors to see the levator shanks. Hold the posterior vaginal wall strongly up with a Langenbeck clamp and push the rectum in the sacral hole with a weighted speculum.

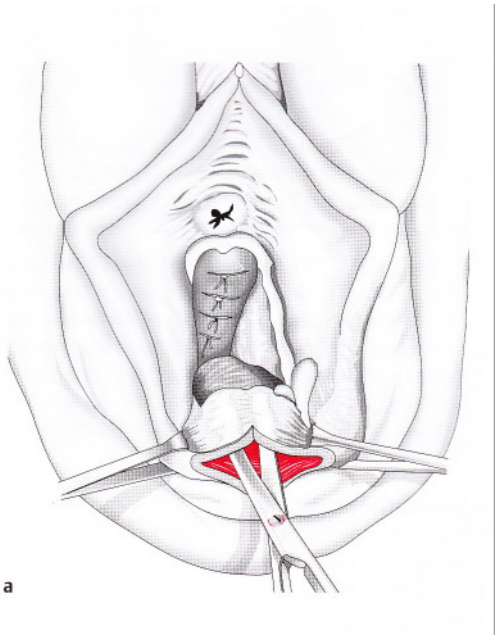
- Unification of the lateral supportive tissue (perineal body). Connect this tensed supportive tissue from the end of the vagina until the lower third of the vagina with single button sutures (absorbable 2-0). This sutures should not include the vaginal wall or tense it.
- Suture of the levators. Suture of the wound. Remove the speculum and push the rectum to the sacrum with one or two fingers and put one or two levator sutures. They should not constrict the vagina. At the posterior comissure put another one or two sutures to unificate the Mm bulbocavernosi. Close the vaginal wall with single button sutures. The vagina should be passable for at least two fingers in ist whole length.

- Problems and solutions
  Enterocele with hernial sac between vagina and rectum: Blunt and sharp preparation of the hernial sac until the end of the vagina. Careful opening of the peritoneal sac. (beware intestinal loops) Contents of the sac will be relocated into the abdomen in slightly head-down-position and the sac will be closed with a purse-string suture (beware: Ureter!) and cut excessive peritoneum. With the connecting of the rectal supportive tissue the sac is sufficiently closed.

- Common mistakes and risks:
  - Too high membranous reconstruction of the posterior commissure (painful sexual intercourse)
  - Lack of levator-preparation (risk of relapse)
  - Unification of the levatores too cranial with constriction of the vagina (painful sexual intercourse)
  - Capture of the vaginal wall-constriction of the vagina (painful sexual intercourse)

- Alternatives:
  - Mesh graft at the posterior compartment (relapse-situation)
  - Stapler technique (STARR) when obstructive dysfunction or intussuseption

- Postoperative treatment:
  - Tight packing of the vagina (soaked with Ovestin cream for painless removal) for 48 hours to avoid haematoma (promote relapse)
  - No lift of heavy weights (not more than 5kg) and no sexual intercourse
  - Don´t push during defecation
  - Aftercare:
  - Local or systemic oestrogen
  - Pelvic floor exercises
  - Behaviour Modification in Lifting, carrying etc.



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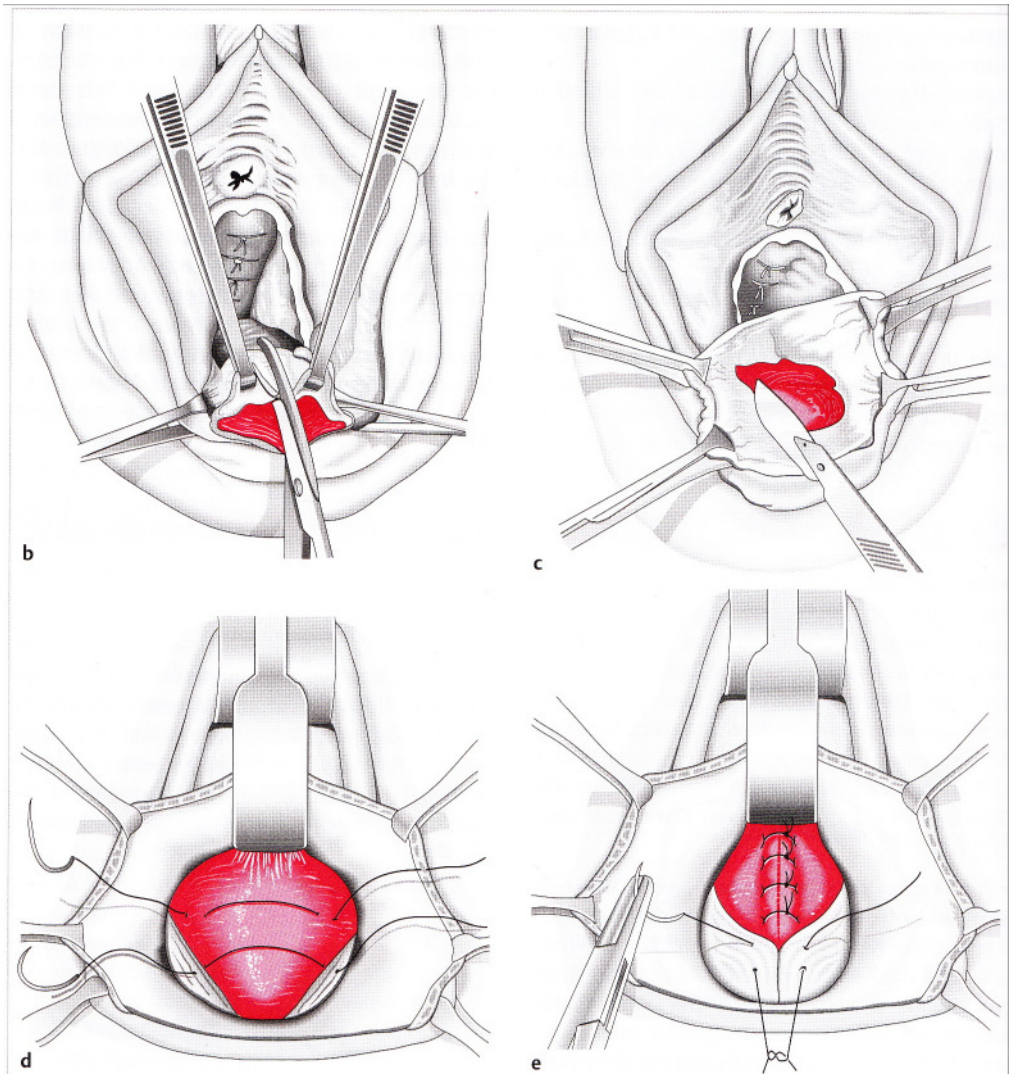

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