Letter to the Editor

Transrectal Repair of Rectocele

To the Editor:—I have read Dr. Irving Block's article entitled "Transrectal Repair of Rectocele Using Obliterative Suture" (Dis Colon Rectum 1986;29:707-11). I certainly applaud his attempts to increase the ability to do ambulatory surgery, and agree that the majority of rectoceles may well be treated in this manner. The technique that he describes is intriguing and may well be very usable in simple rectocele repair. I do question whether simple foreshortening of the rectal mucosa represents the only pathology seen in the rectocele. What is disturbing to me in this article is that he operated upon 60 patients who had rectoceles. Only 14 of these were symptomatic. Of the 60 patients treated, he states that there was no recurrence of the rectocele. The 14 patients who were symptomatic before surgery remained symptom-free afterward. This article does not describe the type of symptoms that he was treating, or the degree of symptoms that the patients had. I would question the value and purpose of operating upon an asymptomatic patient, particularly for something as vague as a rectocele can be. While I applaud his attempts, and agree that the technique is most appealing, especially in patients who may be poor surgical risks, I wonder if the more formal type of rectocele repair should not be done in patients who truly have rectoceles.

JOHN J. O'CONNOR, M.D.
Washington, D.C.

The Authors' Reply

To the Editor:—I am answering Dr. O'Connor's comments on my article entitled "Transrectal Repair of Rectocele Using Obliterative Suture" (Dis Colon Rectum 1986;29:707-11). When I wrote the title, I had a premonition that the first four words of the title might upset the gynecologic surgeon, while the last two words would raise the eyebrows of the Halsteadean purist.

The obliterative suture, essentially, is a tightly drawn running lock-stitch which strangulates and causes to slough the tissues in the grip of each stitch, yet preserves the viability and approximates the tissues at the base of the suture. This surgical maneuver is peculiarly adapted to rectal surgery, since it cannot be used anywhere else in the body but in the rectum it is an amazingly versatile tool for the surgeon. The technique can be used to supplement conventional rectal surgical procedures, but also lends itself admirably to ambulatory surgery for internal hemorrhoids, mucosal prolapse, and rectocele. The obliterative suture technique appears to be the procedure of choice over cryosurgery, rubber-band ligation, and electrocoagulation, infrared, and laser methods for ambulatory rectal surgery.

As to the pathology of rectocele, evidence indicates that the main pathology is attenuation or disruption of the submucosal layer of the anterior rectal wall. With the obliterative suture, the repair takes in the entire thickness of the rectal wall, including the mucosa, submucosa, and muscularis—*not* the mucosa alone. What remains anatomically, the loose areolar tissue of the rectovaginal space and the vaginal epithelium, is not significant in the repair. The so-called rectovaginal septum is really nonexistent. In the vaginal approach, the most important step is plication of the muscular layer of the anterior wall of the rectum.

The symptoms of rectocele are caused by stool being pocketed in the anterior cul-de-sac of the rectocele. The patient is distressed by the need to strain, progressively more with time, to evacuate the rectum during defecation, and has a feeling of incomplete evacuation afterward. The patient may have discovered by herself that her hand pressure on the vulva, or the pressure of her thumb in the vagina, aids in emptying the rectum. Rectocele is a common cause of what is erroneously considered constipation in the female. Diagnosis is gratifyingly simple—by rectal digital examination.

If the patient is to have anorectal surgery, for hemorrhoids as an example, and an asymptomatic rectocele is present, my policy is to repair the rectocele during the operation for two reasons: 1) the repair can be carried out with astonishing ease, requiring an additional five to eight minutes and, 2) rectocele is a progressive condition, and is very likely to cause symptoms in the embarrassingly near future if a repair is not performed. Certainly we must constantly strive for the perfect, the O! Altitudo! anorectal operation.

IRVING R. BLOCK, M.D.
Patchogue, Long Island, New York