Contents

CONTINENCE FOUNDATION OF AUSTRALIA
Level 1, 30–32 Sydney Road
Brunswick, VIC 3056
Tel (03) 9347 2522
Fax (03) 9347 2533
Email info@continence.org.au
www.continence.org.au

NEW ZEALAND CONTINENCE ASSOCIATION INC
PO Box 270, Drury 2247
New Zealand
Association Secretary
Tel (64) 9 238 3172
Freephone 0800 650 659
Email info@continence.org.nz
Web www.continence.org.nz

Winter 2016
Volume 22 Number 2
ISSN 1448–0131

THE OFFICIAL JOURNAL OF THE CONTINENCE FOUNDATION OF AUSTRALIA + THE NEW ZEALAND CONTINENCE ASSOCIATION

CAMBRIDGE PUBLISHING

Published four times a year
by a division of Cambridge Media
10 Walters Drive
Osborne Park, WA 6017
www.cambridgemedia.com.au

Copy Editor Rachel Hoare

Graphic Designer Mark Orange

Advertising enquiries to
Simon Henriques
Cambridge Publishing
Tel (08) 6314 5231
Fax (08) 6314 5299
simonh@cambridgemedia.com.au

The Journal is indexed with CINAHL, Ebsco, infoRMIT.

ADVERTISING

Advertising that appears in the *Australian and New Zealand Continence Journal* conforms to the standards required by the Continence Foundation of Australia Ltd and the New Zealand Continence Association, but endorsement is in no way implied by the publishing of said material. All advertising enquiries should be directed to the publisher, Cambridge Publishing.

EDITORIAL NOTE

The views expressed in the *Australian and New Zealand Continence Journal* are those of the authors and not necessarily those of the Continence Foundation of Australia Ltd, the New Zealand Continence Association, the Editor or the Editorial Committee and must not be quoted as such. While every care is taken to reproduce articles as accurately as possible, the publisher accepts no responsibility for errors, omissions or inaccuracies.

A longitudinal study of asymptomatic rectocoele

ABSTRACT

The aim of this study was to reassess symptoms and signs of asymptomatic rectocoele in women five or more years post initial diagnosis and to determine any factors associated with a worsened condition. Women diagnosed with asymptomatic demonstrable rectocoele and seen at one centre between 1992 and 1999, were recruited via letter, which included information about the study. Once consent was received, participants were sent the Birmingham Bowel and Urinary Symptoms Questionnaire and invited to attend for reassessment of their condition and examination. At this appointment, the main outcomes were the questionnaire, pelvic organ prolapse examination, and Baden-Walker scale.

Of the 316 consecutive women diagnosed with asymptomatic rectocoele who were contacted, 130 letters were returned "address unknown", 18 declined to participate, 49 had died and 19 did not reply. Of 100 replies, 4/100 (4%) declined because they had had prolapse surgery, 96/100 (96%) returned the questionnaire, of whom 6/96 (6%) declined further consultation. Of the 90 remaining women who returned the questionnaire, 62/90 (69%) were examined at a median of 5.9 years (IQR 5.1 to 7.3) and 11 women had undergone prolapse surgery, leaving 51 women in the cohort. In 31/51 (61%) remaining patients, the rectocoele findings were unchanged: all remained asymptomatic; 20/51 (39%) had a more advanced rectocoele on examination but only 5/51 (9.8%) had developed overt symptoms. Rectocoele progression was not associated with age, body mass index, oestrogen status, pelvic floor muscle training, or a history of constipation. Rectocoele progression was associated with greater median bowel symptom scores on Birmingham Bowel and Urinary Symptoms Questionnaire 18.7 (8.2 to 23.7) than non-progression 12.3 (4.2 to 16.7), p=0.027. In most patients (89.2%) with asymptomatic rectocoele, symptoms and signs were unchanged at five years.

Keywords: Asymptomatic rectocoele, constipation, obesity, longitudinal study.

INTRODUCTION

The natural history of asymptomatic rectocoele, that is, a prolapse of the rectum outside its normal confines into the vagina or beyond the introitus without symptoms of "bulge", has received limited attention. Although several studies of uterovaginal prolapse have been reported[2-6], a study of the natural progression of an asymptomatic rectocoele does not appear to have been published. Therefore, it is difficult to advise women with this problem as to whether the condition will inexorably progress to a state warranting treatment, or whether simple observation may be appropriate, or whether attention to presumed exacerbating factors such as constipation or obesity is definitely indicated.

Jacqueline R Woodman
Fellow in Urogynaecology
University Hospital Coventry and Warwickshire (UHCW), Coventry, UK
Previously, The Pelvic Floor Unit, St George Hospital, University of New South Wales, Sydney, NSW, Australia

Tim Cowan
Research Officer
The Pelvic Floor Unit, St George Hospital, University of New South Wales, Sydney, NSW, Australia

Emmanuel Karantanis
Obstetrician and Gynaecologist
The Pelvic Floor Unit, St George Hospital, University of New South Wales, Sydney, NSW, Australia

Kate H Moore*
Urogynaecologist, Director
The Pelvic Floor Unit, St George Hospital, University of New South Wales, Sydney, NSW, Australia
Member *Australian and New Zealand Continence Journal* Editorial Committee
Email k.moore@unsw.edu.au

*Corresponding author

Competing interest statement
The study received funding from The Pelvic Floor Research Trust Fund. The authors have declared they have no relationships or circumstances that present actual or potential conflicts of interest.

Acknowledgements
Preliminary results of these data were presented as an abstract to the IUGA meeting of 20051.

We thank Ms Hayley Leek RN for data collection and Dr Su Sarma for data analysis. We acknowledge a substantial delay in the publication of these full results, due to the international relocation of the first author.

Thus, the purpose of this study was to assess the onset of symptoms over time, to re-evaluate clinical examination at a minimum of five years after the first exam, and to ascertain the impact of suspected risk factors such as constipation or obesity upon the development of worsening symptoms or signs of rectocoele.

MATERIALS AND METHODS

A consecutive series of women seen over an eight-year period (1992–1999) and diagnosed with asymptomatic rectocoele were re-evaluated at a minimum follow-up duration of five years.

At the first clinic visit, a standard medical history was recorded onto a database, and the question "Do you have any symptoms of a bulge into the vagina?" was asked. Those women who responded in the negative were included in the current study. Questions about bowel habits and constipation were also asked. Constipation was defined as straining to defecate and infrequent passage of stools (less than alternate daily). Note that constipation was not considered to be a "symptom" of rectocoele. Height and weight were recorded. Vaginal examination was conducted using the then-standard Baden-Walker Halfway Scoring System of rectocoele, cystocoele and uterine descent[7]. This consists of degrees of descent: mild descent bulging toward the introitus, moderate descent to the level of the hymenal remnant, severe, descent outside hymenal remnant. Asymptomatic rectocoele was diagnosed in women who had no overt symptoms of prolapse but a demonstrable rectocoele on examination.

As the main focus of the Pelvic Floor Unit was urinary incontinence, and conservative treatments were provided as first-line management[8], the urine leakage often responded to conservative therapy, and patients were discharged. Even if they came to surgery for stress incontinence, the unit's policy was not to operate upon asymptomatic rectocoele, especially if it was scored as mild to moderate on examination.

For this study, ethics approval was obtained from South Eastern Area Ethics Committee (reference number 04.127). Re-evaluation of the index cases, women diagnosed with asymptomatic rectocoele 1992–1999, commenced in late 2004. Each woman was sent a letter signed by the original consultant gynaecologist seeking their consent to participate in the study. Upon gaining consent, a letter containing a validated questionnaire, the Birmingham Bowel and Urinary Symptoms Questionnaire (BBUSQ)[9] was sent to assess prolapse and bowel dysfunction symptoms. Box 1 lists the questions in the Evacuation Domain of the BBUSQ, which focuses on obstructive defecation symptoms[9]. The BBUSQ was not given when baseline data were obtained because it was not yet available.

At the end of the questionnaire, women were asked if they wished to attend for re-examination. Women whose letter was returned "address unknown", or who declined to participate were removed from the study. For those women who did not respond to the initial mail out, enquiries were made to the general practitioner listed in their patient notes to determine their whereabouts.

Women who indicated a desire to attend for further assessment were sent a letter explaining the nature of the assessment visit and provided with an appointment. If they did not attend the appointment but phoned to ask for further appointments, these were given. Owing to concerns regarding privacy, patients were not actively pursued if they did not attend their appointment.

At the re-assessment visit, data such as weight gain, onset of menopause, chronic cough, and defecation function were noted. Obstructive defecation symptoms were recorded from the BBUSQ. Because of the known association between colposuspension and subsequent recto-enterocoele[7], details of previous and intervening surgery (including colposuspension) were also obtained. A full POP-Q[5] examination and pelvic floor muscle assessment was performed by a single observer, a urogynaecology research fellow. Details of the level of the rectocoele were recorded in centimetres with respect to the hymenal remnant and the findings were compared with baseline Baden-Walker scoring system results. The POP-Q score of the rectocoele was entered onto the database with a notation as to whether the rectocoele had worsened, remained the same, or improved.

We hypothesised that rectocoele was more likely to worsen in those women who:

a) were older (at the time of the first visit) than women with subsequent unchanged rectocoele

b) weighed more at the first visit

c) had discontinued pelvic floor muscle training in the interim

c) became menopausal in the interceding years.

d) had a history of chronic cough at the first visit

e) had a history of constipation at the first visit

f) developed a new history of constipation in the interim.

Box 1 : Evacuation Domain of the Birmingham Bowel and Urinary Symptoms Questionnaire[3]

Do you have to strain to open your bowels?

How long do you spend in the toilet for each bowel action?

Do you feel that you cannot completely empty your bowel?

Do you use a finger or pressure to help you open your bowels?

Do you use a finger in your vagina to help you open your bowels?

Do you have the urge to open your bowels but are unable to pass a motion?

Do you find it painful to open your bowels?

Do you use laxatives?