

Defecographic Findings in Women with Posterior Vaginal Wall Prolapse and Symptoms of Obstructed Defecation

*A.J. Ortman³, J.C. Lukban¹, J.H. Sun², & O. A. Aguirre^{1,3}; ¹Colorado Gynecology and Continence Center, ²The Sun Clinic, and ³University of Colorado Health Sciences Center, Denver CO

OBJECTIVE: To determine the prevalence of pelvic outlet obstruction (intussusception, rectal prolapse, paradoxical puborectalis contraction, perineal descent, and/or sigmoidocele) in a sample of women with posterior vaginal wall prolapse and obstructed defecation symptoms (excessive straining, incomplete evacuation, need for manual assistance).

METHODS: The authors performed a retrospective chart review of patients from the practices of a single urogynecologist (OAA) and a single colorectal surgeon (JHS) who were sent for defecography within a three and one-half year time period (June 1999 through December 2002). Those found to have both posterior vaginal wall prolapse on examination, and symptoms of obstructed defecation were included. Defecatory complaints, defecographic impressions, and treatments were recorded. Defecography in all patients was performed with oral contrast and a barium-soaked tampon in addition to rectal paste.

RESULTS: A total of ninety charts were reviewed. Sixty-three records were appropriate for analysis. Sixty-two patients (98.4%) were found to have defecographic evidence of rectocele with 16 (25.4%) found to have concomitant enterocele as the anatomic cause of their posterior vaginal wall defect. Thirty patients (47.6%) exhibited evidence of co-existing pelvic outlet obstruction on defecography with a total sample distribution as follows: Six of 63 (9.5%) had intussusception; 13 (20.6%) had rectal prolapse; 3 (4.8%) had paradoxical puborectalis contraction; 6 (9.5%) had perineal descent; 2 (3.2%) had sigmoidocele; and 3 (4.8%) had some combination. One patient (1.6%) exhibited no significant findings on defecography. Two of the three patients with paradoxical puborectalis contraction were treated with biofeedback. Of the remaining twenty-seven subjects with "non-functional" outlet obstruction, twenty had colorectal surgical correction of which nineteen had low anterior resection with rectopexy, and of which one had rectopexy alone. Seventeen of these patients had concomitant rectocele repair, with fourteen undergoing additional urogynecologic procedures at the same operative setting.

CONCLUSION: Those with symptoms of obstructed defecation in the presence of posterior vaginal wall prolapse should undergo colorectal evaluation including defecography given the likely prevalence of pelvic outlet obstruction in such patients. Appropriate preoperative diagnosis of co-existing colorectal disorders would allow for combined surgical management.

Modified Manchester Questionnaire Validation Study

*S. Kwon; University of North Carolina at Chapel Hill, Chapel Hill, NC; for the Pelvic Floor Disorders Network (PFDN)

OBJECTIVE: To date, no measures of fecal incontinence severity or its impact on quality of life have been validated for telephone interview. The aims of our study were to: (1) Compare responses on a self-administered versus a telephone-administered Fecal Incontinence Severity Inventory (FISI). (2) Compare responses on the Fecal Incontinence Quality of Life questionnaire (FIQOL) to the telephone-administered Manchester Health Questionnaire (MHQ) modified for telephone administration and US English. (3) Assess test-retest reliability of the telephone-administered FISI and MHQ. (4) Assess the internal consistency of the MHQ subscales.

METHODS: Fifty-one consecutive female patients evaluated for fecal incontinence were invited to participate. Nine patients were determined to be ineligible and five patients declined. Average age of participants was 49.1±10.3 years vs. 44.2±7.5 years for non-participants. Thirty women returned self-administered questionnaires and 31 completed a first telephone interview. In addition, 21 women completed a second telephone interview for use in test-retest reliability calculations (average interval 23 days).

RESULTS: (1) The FISI was scored using patient-derived weights. FISI scores obtained by telephone interview were significantly lower than those yielded by self-administered questionnaire (9.85±4.19 vs. 6.19±3.09, p<0.001). A higher FISI score is associated with more severe fecal incontinence. The results from both administrations had good correlations (r=0.50, p<.02). (2) To assess the convergent validity of the MHQ relative to the FIQOL, four FIQOL subscales (depression, embarrassment, lifestyle, and coping) plus the FISI were compared to the 8 subscales of the MHQ with which they shared the greatest content. These correlations ranged from 0.49 to 0.91. All correlations were statistically significant, suggesting that the two scales measure the same construct. (3) Test-retest reliability for the 8 MHQ subscales ranged from 0.63 to 0.96 (median r=0.80). Test-retest reliability for the two telephone administrations of the FISI was r=0.75. (4) Cronbach alphas for the 8 MHQ subscales ranged from 0.67 to 0.93 (median alpha=0.85).

CONCLUSIONS: Telephone-administered versions of the MHQ and the FISI showed good to excellent validity, internal consistency, and test-retest reliability. The telephone-administered version of the FISI yielded lower severity scores than the questionnaire version, but the difference (1.75 units) was not clinically significant (maximum score 61). (Supported by NICHD grants U01 HD41249, U10 HD41268, U10 HD41248, U10 HD41250, U10 HD41261, U10 HD41263, U10 HD41269, U10 HD41267)