

CHIRURGIA COMBINATA GINECOLOGICA E RETTALE CON APPROCCIO TRANSPERINEALE PER IL TRATTAMENTO DELLE DISFUNZIONI COMPLESSE DEL PAVIMENTO PELVICO. RISULTATI FUNZIONALI E QUALITÀ DI VITA.

Lucia Morganti¹, Francesca Gubbiotti¹, Simona Ascanelli¹, Ruby Martinello², Gennaro Scutiero², Giorgio Cremonini², Pantaleo Greco²

¹Clinica Chirurgica, Università degli Studi di Ferrara

²Clinica Ostetrica e Ginecologica, Università degli Studi di Ferrara

Topic: Disfunzioni complesse del pavimento pelvico

Purpose: To evaluate clinical outcomes and quality of life (QoL) in patients with complex pelvic floor disorders (PFDs) treated by a multidisciplinary group with anterior or posterior vaginal wall repair with or without vaginal hysterectomy (VAHY) associated to stapled trans-anal rectal resection (STARR).

Methods: Retrospective cohort study including all patients with complex PFDs managed by a multidisciplinary and interprofessional pelvic floor team, receiving combined STARR and urogynecologic surgery at our institution over a two-year period. Patient's clinical outcomes and QoL before and after the combined surgical treatment was evaluated by submitting Pelvic Floor Disorders Distress Inventory (PFDI) and Pelvic Floor Disorders Impact Questionnaire (PFIQ), respectively. For functional evaluation, preoperative and postoperative obstructed defecation syndrome scores and anorectal manometry were employed.

Results: Between December 2012 and December 2014, 18 consecutive patients underwent combined STARR and anterior or posterior vaginal wall repair with or without VAHY. PFDI, PFIQ and obstructed defecation syndrome scores were all improved after combined surgical repair ($p < 0,0001$) (Table 1). At postoperative anorectal manometry, rectal compliance increased ($p=0.03$) while mean resting pressure and squeeze pressure did not vary significantly (Table 2). No patients required re-operation at 22-month follow up, while one patient had a prolapse recurrence one year after the operation.

Conclusions: These preliminary data support the multidisciplinary interprofessional management of complex PFDs to achieve good clinical outcomes and QoL in patients undergoing trans-perineal surgery. A multidisciplinary approach may help the decision-making process for complex PFDs and may reduce single-specialist management failure.

Table 1. The clinical outcomes and health-related QoL of patients with complex PFDs who underwent combined surgical repair by a multidisciplinary team.

	Before Surgery [Median (IQR 75-25)]	After Surgery [Median (IQR 75-25)]	p
Pelvic Floor Distress Inventory – PFDI (range 0-300)	170.6 (163.5-192.7)	88.0 (68.8-123.7)	<0.0001
Pelvic Organ Prolapse Quantification – POP-Q (grade 0-4)	2.0 (2.0-3.0)	0 (0-1.0)	<0.0001
Obstructed Defecation Syndrome – ODS (range 0-31)	24.0 (18.0-26.0)	10.5 (6.0-11.0)	<0.0001
Wexner Scale Constipation scoring system (range 0-30)	21.0 (17.0-21.0)	12.0 (7.0-13.0)	<0.0001
Cleveland Clinic Incontinence Score – CCIS (0-20)	5.0 (3.0-9.0)	8.0 (3.0-9.0)	0.4258
Pelvic Floor Impact Questionnaire – PFIQ (range 0-300)	197.4 (156.6-213.9)	107.1 (80.5-137.2)	<0.0001

Table 2. Functional results of patients with complex PFDs who underwent combined surgical repair by a multidisciplinary team.

	Before Surgery [Median (IQR 75-25)]	After Surgery [Median (IQR 75-25)]	p
Medium Anal Resting Pressure	34.5 (26.0-45.0)	34 (28.0-45.0)	0.67
Maximum Anal Resting Pressure	65.0 (49.0-81.0)	63.5 (55.0-78.0)	0.55
Medium Anal Squeeze Pressure	34.5 (25.0-53.0)	41.0 (30.0-51.0)	0.1
Maximum Anal Squeeze Pressure	89.0 (60.0-120.0)	90.0 (62.0-130.0)	0.37
Rectal Compliance	7.6 (4.0-15.0)	11.2 (5.8-15.0)	0.03

Medium and maximum anal resting pressure are expressed in mmHg, with respectively normal value of > 20 mmHg, and between 50-80 mmHg; *Medium and maximum anal squeeze pressure* are expressed in mmHg, with respectively normal value of >20 mmHg, and between 100-180 mmHg; *Rectal Compliance* has normal value of 15-16, expressed in ml/cmH₂O

References

1. Barber MD, Kuchibhatla MN, Pieper CF, Bump RC (2001) Psychometric evaluation of 2 comprehensive condition-specific quality of life instruments for women with pelvic floor disorders. *Am J Obstet Gynecol* 185(6):1388-1395.
2. Boccasanta P, Venturi M, Spennacchio M, Buonaguidi A, Airoidi A, Roviario G (2010) Prospective clinical and functional results of combined rectal and urogynecologic surgery in complex pelvic floor disorders. *Am J Surg* 199(2):144-153.

3. Chan MC, Schulz JA, Flood CG, Rosychuk RJ (2010) A retrospective review of patients seen in a multidisciplinary pelvic floor clinic. *J Obstet Gynaecol Can* 32(1):35-40
4. Renzi A, Izzo D, Di Sarno G, Izzo G, Di Martino N (2006) Stapled transanal rectal resection to treat obstructed defecation caused by rectal intussusception and rectocele. *Int J Colorectal Dis* 21:661–667.
5. Pechlivanides G, Tsiaoussis J, Athanasakis E, Zervakis N, Gouvas N, Zacharioudakis G, Xynos E (2007) Stapled transanal rectal resection (STARR) to reverse the anatomic disorders of pelvic floor dyssynergia. *World J Surg* 31(6):1329–1335.
6. Madjar S, Evans D, Duncan RC, Gousse AE (2001) Collaboration and practice patterns among urologists and gynecologists in the treatment of urinary incontinence and pelvic floor prolapse: a survey of the International Continence Society members. *Neurourol Urodyn* 20(1):3-11.