Definition: Posterior repair is a surgical procedure to correct a rectocele. A rectocele occurs when the thin wall of tissue that separates the rectum from the vagina weakens, allowing the rectum to bulge into the back wall of the vagina. A posterior repair returns the rectum back into its normal position and strengthens the wall between the rectum and the vagina. A perineoplasty is the reconstruction of the opening of the vagina (introitus) and the area between the anus and the vagina (perineum). These procedures are performed completely through the vagina, no abdominal incisions are made.

Procedure: After sedation from general anesthesia is achieved; the surgeon will begin by placing a catheter in the bladder to keep it empty during the procedure. An incision is then made along the back wall of the vagina and a measured portion of the weakened and stretched vaginal tissue (that covers the rectum) is dissected away from the rectal wall. The rectal bulge is then identified and placed back into its normal position and held in place with dissolvable sutures. The strong supportive tissues on each side of the pelvis are then brought back to the midline and sutured together; this recreates a strong muscular wall between the rectum and the vagina. Lastly, a perineoplasty is preformed. The opening of the vagina (introitus) and the area between the anus and the vagina (perineum) are reconstructed by the surgeon, much like an episiotomy repair after vaginal childbirth. The surgeon may remove some skin during the perineoplasty to restore the normal structure of the external aspect of the vaginal opening. Sometimes the surgeon may place a gauze pack in the vagina temporarily to reduce vaginal bleeding or bruising.

Diagnosis: The reason to have a posterior repair and perineoplasty is a Rectocele: the bulging of the rectum into the back wall of the vagina, due to the weakening of the wall that separates the rectum and the vagina. Factors that contribute to the loss of normal support between the rectum and the vagina are: pregnancy and childbirth, menopause, chronic coughing, obesity, chronic constipation, years of strenuous activity or heavy lifting, and/or other gynecological or rectal surgeries. The most common symptoms associated with a rectocele are: constipation, difficulty with evacuation during a bowel movement, the need to press against the vagina and/or space between the rectum and the vagina in order to have a bowel movement, uncomfortable or painful sexual intercourse, and/or the sensation of pressure or fullness in the vagina.

Expectations of Outcome: A Posterior Repair and Perineoplasty typically take approximately 60 to 90 minutes to complete. When you awake from surgery you may have an IV, bladder catheter, and possibly a vaginal packing in place. Most patients will go home the same day as surgery while others may have additional surgeries with their posterior repair and will stay one night in the hospital. Recovery from a posterior repair typically takes 4-6 weeks; it is very important to abstain from sexual intercourse and heavy lifting until released by your doctor. Following the recovery from a posterior repair, it is expected for patients to have improvement with incomplete bowel emptying and/or constipation. It is also expected for patients to have relief from the vaginal pressure/fullness sensation and intercourse should be more comfortable.
Possible Complications of the Procedure: All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list of some specific complications so that you may ask questions if you are still concerned. Aside from anesthesia complications, a list of possible complications, would include, but are not limited to:

- **Organ Injury:** During any part of the procedure, any organ in the pelvis (intestine, bladder, uterus, ureter, rectum, etc) can be inadvertently injured. A rectal or bowel Injury is most likely in this type of surgery. It is possible to make a hole in the deeper tissue of the rectum or bowel. In most cases the hole can be repaired and there are no long-term problems. However, if a surgical injury is major or the repair is complicated, more extensive surgery may be necessary. This may prolong the hospital stay and recovery and might also necessitate additional surgical procedures in the future.

- **Infections:** Although prophylactic antibiotics are given through your IV prior to surgery, post operative infections can still occur. The most common type of infection is a bladder infection (UTI). A UTI can cause burning with urination, increased urinary frequency, blood in the urine, pelvic or back pain, fever and or chills. An infection can also occur in the incisions in the vagina and/or perineum. If an infection is present the patient may have a fever more than 100 degrees, increasing pain in the vagina/rectum, severe constipation, and foul smelling or odorous vaginal discharge. The incision along the perineum may also be red and warm to touch if an infection is present. Pneumonia is an infection involving the lungs. Pneumonia may occur from lack of deep breathing after surgery due to pain from the incision sites. Early ambulation and deep breathing helps to reduce the risk of pneumonia. While rare, sepsis is another infection that can occur. Sepsis is when the infection enters the bloodstream and can make you very ill. Sepsis symptoms usually include: fever, chills, weakness, nausea, vomiting and or confusion. If any of the above symptoms of infection occur, call our office.

- **Rectal Spasm/pressure:** The Levator muscles are typically part of the connective tissue that is sewn back together to strengthen the wall between the rectum and the vagina. The muscles have commonly been separated for some time and they may spasm during the weeks following surgery as they get used to their new position. Your pain medication should help. If the spasms are severe, then contact the office during regular hours to request additional medications to relax the muscles.

- **Constipation:** It is very important to avoid becoming constipated after surgery. Constipation, hard bowel movements, or straining after surgery could damage the repair. Unfortunately; anesthesia, pain medications, decreased activity, and post-operative pain can all cause constipation. It is best to start fiber supplements prior to surgery and maintain them after surgery to minimize the risk of constipation. Laxatives and stool softeners are also ok to take after surgery.

- **Vascular Injury:** Any of the vessels inside the pelvis are at potential risk for injury during a posterior repair. Inadvertent injury to a blood vessel can occur as instruments are introduced into the pelvis, during the repair of the vaginal and rectal tissues, or from electrical injury to the vessel wall. Another type of vascular injury occurs when the sealed or sutured vessel comes loose after the procedure has been finished. Most of these injuries are recognized and resolved at the time of surgery. Major vessel injury or delayed bleeding may require additional surgery, prolonged hospital stay and recovery, readmission to the hospital, and blood transfusion.

- **Blood Loss/Transfusion:** The vaginal region is vascular. Usually the blood loss in this procedure is minimal. In some cases blood loss can be significant enough to necessitate a blood transfusion. If a transfusion is necessary, there is a small risk of blood related infections such as Hepatitis or HIV.

- **Painful Intercourse and Vaginal Shortening:** After a posterior repair, the depth of the vagina may be lessened and the angle changed, causing some women to complain of pain or difficulty with intercourse after surgery. This pain is usually temporary but may be permanent. It is possible for the introitus (opening of the vagina) to become too tight, making intercourse difficult or uncomfortable. Vaginal dilatation or surgery to increase the size of the opening may be necessary. It is
extremely important to not resume intercourse (vaginal penetration) until released to do so by your surgeon. If you have sudden onset of watery or bloody discharge beyond what a light sanitary pad would take care of, then call our office.

- **Hematoma:** When a small blood vessel continues to bleed after the procedure is over, the area of collected blood is referred to as a hematoma. The body normally re-absorbs this collection over a short period of time but surgical drainage may be necessary, however, this is rare.

- **Chronic Pain:** With any procedure, a patient can develop chronic pain in an area that has undergone surgery. Typically, the pain disappears over time, although some feeling of numbness may persist.

- **Treatment Failure:** While a posterior repair has a high success rate, there is a chance that the procedure can fail in the months or years to follow. Prolapse could occur again in the future, in the same or different part of the vagina.

- **Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE):** In any operation (especially longer operations), you can develop a clot in a vein of your leg (DVT). Typically, this presents two to seven days post op as pain, swelling and tenderness to touch in the lower leg area. Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This presents as shortness of breath and chest pain. If you notice any of these signs, call our office.

- **Lower Extremity Weakness/Numbness:** While this is rare, it is possible that due to the positioning of your legs in the lithotomy position (legs in the air/stirrup) for a long period of time or direct injury to nerves by surgical instruments, you may develop weakness or numbness in your legs. It is usually self-limited, with a return to baseline.

- **Permanent Injury/Death:** Permanent injuries from surgery are rare but do occur. Permanent injuries may involve removal of organs not planned during the original surgery, pain that does not resolve with time, or diminished ability to enjoy life. Death is extremely rare from Gynecologic surgery but does occur. The most common reasons are massive blood loss, overwhelming sepsis, heart attack, DVT/Pulmonary embolus, stroke, and anesthesia complications.

**Additional Procedures/Consultations:** If there are unanticipated findings, difficulty during the surgery, or a situation where your doctor does not believe that he has the expertise to accomplish all of your case then an intra-operative consultation may be necessary. Intra-operative consultation is when another physician or surgeon is asked to give recommendations, assist or take over a surgical case. This occurs at your doctor’s discretion for your safety and without regard to whether the other physician is on your insurance panel. By signing below you give consent to intra-operative consultations if necessary.

**Consent:** I, Dr._________________________ have counseled ___________________________ regarding her planned surgery. In my professional opinion I believe that the surgery is reasonable and most likely will result in a beneficial outcome. It is my belief that the patient has considered her options and fully weighed the risks of surgery.

Signed__________________________________________ Date__________________ Time______________

I,_________________________, believe that the surgical procedure listed above is the best option for me. My situation is not an emergency and I understand that I have other options, including not having surgery. I understand that complications, bad outcomes, and unanticipated events will occur occasionally during surgery and recovery. I understand that my doctor and his surgical team are not perfect and at no point have I been guaranteed any outcomes or results. I have been given the opportunity to ask all my questions and I believe that I have all the information necessary to make a reasonable decision. Therefore, I elect to give my consent and proceed with the above surgery, as witnessed by my signature below.

Patient Signature__________________________________________ Date________________

Witness Signature__________________________________________ Date________________