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Surgical Management of Combined Rectocele and Cystourethrocele and Determinants of Recurrence

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ABSTRACT

Combined rectocele and cystourethrocele represent a frequent and therapeutically challenging form of pelvic floor dysfunction. Although numerous surgical techniques have been developed to address anterior and posterior compartment defects, long-term stability remains variable, and recurrence continues to be reported across different operative approaches. The coexistence of these conditions raises important questions regarding optimal surgical strategy, selection of access route, choice of reinforcement material, and adequacy of multilevel reconstruction. This narrative review analyzes contemporary evidence on native tissue repair, levatorplasty, mesh-augmented techniques, laparoscopic and robotic procedures, and combined reconstructive strategies in the management of rectocele associated with cystourethrocele. Particular attention is given to anatomical restoration versus functional outcome, predictors of surgical success, and factors associated with recurrence. Available data indicate that recurrence is influenced not only by technical execution but also by baseline pelvic floor integrity, multilevel involvement, connective tissue quality, and biomechanical load redistribution after repair. Comparative studies demonstrate that isolated compartment correction may lead to symptom persistence or progression in adjacent structures, while more extensive reconstructions do not uniformly translate into superior long-term outcomes. The evidence suggests that durability depends on balanced load distribution, appropriate patient selection, and integration of functional assessment into surgical decision-making. Understanding determinants of recurrence in combined rectocele and cystourethrocele is essential for refining operative strategy and improving long-term pelvic floor stability.

Keywords: rectocele; cystourethrocele; pelvic organ prolapse; surgical repair; levatorplasty; mesh repair; ventral rectopexy; recurrence; reconstructive surgery

INTRODUCTION

Surgical treatment of rectocele combined with cystourethrocele remains a subject of ongoing debate despite the substantial evolution of operative techniques

over the past two decades. Both conditions are traditionally classified within distinct pelvic compartments, yet clinical practice demonstrates that combined forms are frequent and often present with overlapping defecatory

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and urinary symptoms. Contemporary surgical literature emphasizes the necessity of individualized management strategies in pelvic organ prolapse; however, a unified algorithm for patients with simultaneous anterior and posterior defects has not been firmly established [1,16].

Historically, operative correction focused on the dominant symptomatic compartment. Transvaginal posterior colporrhaphy and rectovaginal fascial plication were widely used to address rectocele, whereas anterior repair or apical suspension techniques were applied for cystourethrocele. Comparative investigations of laparoscopic ventral rectopexy and transvaginal repair illustrate that different access routes may achieve comparable short-term anatomical results, yet functional outcomes and long-term stability remain heterogeneous [1,5]. Similar variability has been observed in laparoscopic sacrocolpopexy and sacrocolpoperineopexy procedures, where satisfactory anatomical repositioning does not always translate into durable symptom resolution [6,10].

The introduction of mesh-augmented techniques aimed to reinforce weakened support structures and reduce recurrence. Early enthusiasm for synthetic materials was based on improved anatomical correction rates; however, subsequent reports highlighted complications related to erosion, pain, and altered pelvic dynamics, leading to reconsideration of their universal application [3,14]. In parallel, the non-mesh era prompted renewed interest in native tissue repairs and levator-based reconstructions, though outcome variability persists [14,16].

Randomized and comparative studies in obstructed defecation syndrome further illustrate that procedure selection significantly influences symptom improvement but does not eliminate recurrence risk [19,20]. Long-term analyses of stapled and transanal procedures demonstrate that initial symptomatic relief may be followed by progressive dysfunction or structural relapse in a subset of patients [4]. These findings suggest that technical refinement alone does not fully address the underlying determinants of postoperative stability.

Emerging evidence also indicates that surgical decision-making is influenced by patient-specific structural and functional characteristics rather than by a single dominant anatomical defect. Analytical models integrating multiple diagnostic parameters have shown that operative indication in pelvic floor disorders often depends on combined morphological and functional criteria [15]. Moreover, recurrence studies emphasize that multilevel involvement and baseline tissue integrity significantly affect long-term outcomes [9,17].

Taken together, these observations highlight the complexity of managing combined rectocele and cystourethrocele.

The coexistence of anterior and posterior compartment defects challenges the traditional compartment-oriented surgical paradigm and raises critical questions regarding optimal reconstruction strategy, extent of correction, and predictors of recurrence. The present review aims to analyze contemporary surgical approaches and to clarify the determinants of long-term stability in patients undergoing operative management for combined rectocele and cystourethrocele.

MATERIALS AND METHODS

This study was designed as a narrative review aimed at analyzing contemporary surgical strategies for the management of combined rectocele and cystourethrocele and identifying determinants of postoperative recurrence. The methodological approach focused on structured literature selection and thematic synthesis rather than quantitative meta-analysis.

A targeted search of PubMed, Scopus, and Web of Science databases was performed. The following key terms and combinations were used: rectocele repair, cystourethrocele, pelvic organ prolapse surgery, levatorplasty, ventral rectopexy, mesh repair, transvaginal repair, robotic surgery, obstructed defecation syndrome, and recurrence after pelvic floor surgery. Boolean operators AND and OR were applied to refine search results and combine anatomical and surgical concepts.

The search period primarily covered publications from 2021 to 2025 to reflect current operative techniques and evolving trends in pelvic floor reconstruction. Only peer-reviewed articles published in English were considered. Priority was given to randomized controlled trials, prospective cohort studies, comparative surgical analyses, long-term follow-up reports, and structured clinical reviews that addressed surgical outcomes, recurrence rates, or predictors of failure in rectocele and pelvic organ prolapse surgery.

Exclusion criteria included isolated case reports without broader analytical relevance, studies limited exclusively to non-surgical conservative management, and publications focusing on isolated anterior or posterior compartment pathology without discussion of combined or multilevel involvement.

From the initial search results, 20 publications were selected based on methodological quality and thematic relevance. Data extraction focused on four principal domains:

Outcomes of native tissue repairs and levator-based reconstructions.

Results of mesh-augmented and minimally invasive procedures, including laparoscopic and robotic approaches.

Comparative analyses of different operative strategies.

Identified predictors of recurrence and factors influencing long-term stability.

Selected studies were evaluated qualitatively. Emphasis was placed on identifying recurring patterns in surgical outcomes, analyzing mechanisms of relapse, and determining whether recurrence reflected technical insufficiency or broader biomechanical limitations. The synthesis aimed to construct a conceptual framework explaining why recurrence persists despite advances in operative technique.

RESULTS

Analysis of the selected studies revealed substantial heterogeneity in operative approaches and outcome assessment, yet several consistent patterns emerged regarding durability, functional recovery, and recurrence in combined rectocele and cystourethrocele. The findings were structured according to operative strategy and determinants of postoperative stability.

Native Tissue Repairs and Levator-Based Reconstruction. Traditional transvaginal posterior colporrhaphy and rectovaginal fascial plication remain widely performed procedures. Comparative evaluation of laparoscopic ventral mesh rectopexy versus transvaginal posterior repair demonstrated that while anatomical correction can be achieved with both techniques, symptom improvement varies and long-term recurrence remains a concern [1].

Native tissue posterior compartment repair has shown acceptable short-term anatomical outcomes; however, variability in functional improvement and recurrence rates persists [14]. Transvaginal peritoneocele repair combined with anterior levatorplasty illustrates that reinforcement of muscular support may enhance structural stability, yet success depends on baseline tissue integrity and extent of multilevel involvement [13].

Obliterative and reconstructive vaginal procedures for advanced prolapse have also demonstrated that anatomical repositioning does not necessarily guarantee sustained functional balance, particularly in cases with combined compartment defects [2,8]. These findings suggest that isolated reinforcement of one structural layer may be insufficient when anterior and posterior compartments are simultaneously weakened.

Mesh-Augmented and Minimally Invasive Techniques. The introduction of mesh-based techniques

aimed to improve anatomical durability by compensating for tissue deficiency. Laparoscopic ventral mesh rectopexy has been reported to provide effective anatomical correction; however, comparison with transperineal mesh repair indicates that functional results and patient satisfaction depend on proper patient selection and extent of pelvic floor involvement [5].

Polyvinylidene fluoride and other synthetic materials have been evaluated for reinforcement in obstructed defecation syndrome, showing improved anatomical outcomes but raising concerns regarding long-term safety and biomechanical adaptation [3]. Long-term consequences of stapled transanal procedures reveal that initial symptom relief may be followed by progressive dysfunction in some patients, highlighting limitations of procedure-focused approaches [4].

Robotic and laparoscopic sacrocolpopexy techniques demonstrate high anatomical success rates, yet radiological follow-up indicates that dynamic pelvic relationships may not be fully restored despite structural correction [6,10]. Comparative analyses of robotic ventral mesh rectopexy suggest variability in outcomes during early institutional experience, reinforcing the role of technical factors and learning curves [10].

Combined Procedures and Surgical Strategy Evolution. Combined laparoscopic–vaginal approaches and multicomponent reconstructions have been proposed to address simultaneous anterior and posterior defects [11,18]. While these strategies aim to achieve comprehensive anatomical restoration, outcome studies demonstrate that increased procedural extent does not uniformly reduce recurrence rates [18].

Time-trend analyses indicate a gradual shift toward individualized surgical selection based on patient-specific characteristics rather than standardized compartment-based algorithms [16]. Comparative trials of laparoscopic versus transanal rectocele repair reveal that reduction in rectocele size does not consistently correlate with improvement in obstructed defecation symptoms [20].

Determinants of Recurrence. Recurrence after pelvic organ prolapse surgery is influenced by multiple interacting factors. Prospective cohort data identify multilevel pelvic involvement and connective tissue weakness as significant predictors of relapse [9]. Analytical studies integrating diagnostic parameters demonstrate that operative indication and outcome are determined by combined morphological and functional characteristics rather than by a single anatomical defect [15].

Preoperative predictors of success after transvaginal rectocele repair indicate that symptom profile and baseline pelvic support integrity significantly affect long-

term results [18]. Evidence suggests that recurrence often reflects global pelvic floor instability and biomechanical load redistribution rather than isolated technical failure.

Overall, the analyzed studies support the conclusion that combined rectocele and cystourethrocele require a comprehensive surgical strategy that accounts for multilevel structural support and functional coordination. Persistence of recurrence across diverse operative techniques suggests that durability depends not only on procedural selection but also on the underlying biomechanical environment of the pelvic floor.

DISCUSSION

The analysis of contemporary surgical literature demonstrates that management of combined rectocele and cystourethrocele remains characterized by variability in both operative strategy and long-term outcomes. Although numerous techniques are capable of restoring anatomical alignment, durability and functional normalization are not consistently achieved. This discrepancy suggests that recurrence is not merely the result of technical imperfection but reflects broader biomechanical and structural determinants.

Native tissue repair continues to play a central role in posterior and anterior compartment reconstruction. However, comparative data indicate that anatomical correction achieved through fascial plication does not uniformly translate into sustained symptom relief, particularly in patients with multilevel pelvic involvement [1,14]. The incorporation of levator-based reinforcement appears to improve structural stability in selected cases, yet outcomes remain dependent on baseline muscular integrity and tissue quality [13]. These observations imply that the mechanical environment in which reconstruction is performed substantially influences postoperative durability.

Mesh-augmented procedures were introduced to address tissue deficiency and reduce recurrence. Laparoscopic ventral mesh rectopexy and related minimally invasive techniques demonstrate favorable anatomical success rates, yet functional results vary and complications related to synthetic materials remain a concern [3,5]. Long-term analyses of stapled transanal procedures further illustrate that initial symptomatic improvement may not prevent progressive dysfunction in a subset of patients [4]. Even advanced laparoscopic and robotic sacrocolpopexy approaches, despite high anatomical correction rates, do not fully normalize pelvic floor dynamics when evaluated by imaging studies [6,10].

The recurrence literature underscores the importance of multilevel assessment. Prospective cohort investigations identify combined compartment defects and global pelvic floor weakness as significant risk factors for relapse after surgery [9]. Morphological parameters reflecting generalized support laxity, such as increased genital hiatus dimensions, correlate with poorer long-term outcomes [15]. Moreover, analytical models integrating clinical and functional variables demonstrate that operative indication and success depend on the interplay of structural and physiological factors rather than isolated anatomical measurements [15,18].

These findings collectively support the concept that combined rectocele and cystourethrocele represent a manifestation of systemic pelvic floor instability. Correction of a single compartment, even when technically adequate, may alter load distribution and unmask weakness in adjacent structures. Conversely, more extensive reconstructions do not necessarily guarantee superior outcomes if underlying biomechanical imbalance persists. The persistence of recurrence across diverse surgical modalities suggests that long-term stability depends on achieving balanced load redistribution and coordinated functional support rather than simply reinforcing weakened tissue.

Recognition of these determinants has important implications for surgical planning. Comprehensive preoperative evaluation incorporating anatomical imaging, functional testing, and assessment of multilevel involvement may facilitate more rational procedure selection. Although no single operative technique can be considered universally optimal, individualized reconstruction based on global pelvic floor assessment appears more consistent with the pathophysiology of combined prolapse.

In this context, future refinement of surgical strategies should focus not only on technical innovation but also on restoration of biomechanical equilibrium and preservation of dynamic pelvic floor function. Understanding recurrence as a consequence of systemic instability rather than isolated repair failure may represent a critical step toward improving long-term outcomes in patients with combined rectocele and cystourethrocele.

CONCLUSION

Surgical management of combined rectocele and cystourethrocele remains complex and associated with variable long-term stability. Contemporary evidence indicates that recurrence is influenced by multilevel pelvic involvement, baseline tissue integrity, and biomechanical

load redistribution rather than by isolated technical factors alone.

Anatomical correction achieved through native tissue repair, mesh reinforcement, or minimally invasive techniques does not uniformly ensure durable functional restoration. Integrated assessment of structural and functional parameters is essential for optimizing surgical decision-making.

Recognition of combined rectocele and cystourethrocele as manifestations of global pelvic floor instability provides a conceptual framework for improving reconstructive strategy and reducing recurrence.

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Ethical Approval. This study is a narrative review of previously published literature and does not involve human participants, patient data, or experimental interventions. Therefore, ethical committee approval was not required.

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Data Availability. All data analyzed in this review are derived from publicly available published studies cited in the reference list.

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QUSHMA RECTOCELE VA CYSTOURETHROCELENI JARROHLIK USULLARINI QULLASH BILAN DAVOLASH VA QAYTALANISH OMILLARI

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Annotatsiya

Rectocele va cystourethrocele kombinatsiyalangan shakllari tos tubi disfunktsiyasining murakkab va ko'p omilli ko'rinishlaridan biri hisoblanadi. So'nggi yillarda ushbu patologiyani jarrohlik davolash usullari sezilarli darajada takomillashgan bo'lsa-da, uzoq muddatli natijalar va qaytalanish chastotasi hali ham dolzarb muammo bo'lib qolmoqda. An'anaviy yondashuvlarda oldingi va orqa kompartment nuqsonlari alohida ko'rib chiqilgan, biroq klinik kuzatuvlar ularning o'zaro bog'liqligini va ko'p darajali yetishmovchilik mavjudligini ko'rsatadi. Ushbu sharh maqolada nativ to'qima asosidagi plastika, levatoroplastika, setkali rekonstruksiya, laparoskopik va robotik texnikalar hamda kombinatsiyalangan operatsiyalar tahlil qilinadi. Jarrohlik natijalariga ta'sir qiluvchi asosiy omillar sifatida to'qima sifati, ko'p darajali zararlanish, biomekanik yuklamaning qayta taqsimlanishi va funktsional ko'rsatkichlar muhokama qilinadi. Tadqiqotlar shuni ko'rsatadiki, qaytalanish ko'pincha faqat texnik xatolik bilan emas, balki tos tubi tayanch tizimining umumiy beqarorligi bilan bog'liq. Shu bois, kombinatsiyalangan rectocele va cystourethrocele holatlarida jarrohlik strategiya nafaqat anatomik defektни bartaraf etishga, balki biomekanik muvozanatni tiklashga ham qaratilishi lozim.

Kalit so'zlar: rectocele; cystourethrocele; tos tubi disfunktsiyasi; jarrohlik davolash; levatoroplastika; setkali rekonstruksiya; qaytalanish; rekonstruktiv jarrohlik

ХИРУРГИЧЕСКОЕ ЛЕЧЕНИЕ СОЧЕТАННЫХ ФОРМ РЕКТОЦЕЛЕ И ЦИСТОУРЕТРОЦЕЛЕ И ФАКТОРЫ РЕЦИДИВА

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Аннотация

Сочетанные формы ректоцеле и цистоуретроцеле представляют собой сложный вариант дисфункции тазового дна, характеризующийся многоуровневым нарушением опорной системы. Несмотря на совершенствование хирургических методов лечения, проблема нестабильности отдалённых результатов и рецидивов остаётся актуальной. Традиционные подходы, ориентированные на коррекцию отдельного компартмента, не всегда обеспечивают долговременное восстановление функции, что обусловлено взаимосвязью переднего и заднего отделов тазового дна. В обзоре проанализированы современные хирургические методы, включая пластику собственными тканями, леваторопластику, применение синтетических имплантов, лапароскопические и роботические технологии, а также комбинированные реконструктивные вмешательства. Особое внимание уделено факторам, определяющим риск рецидива, таким как качество соединительной ткани, выраженность многоуровневого поражения и особенности перераспределения биомеханической нагрузки после операции. Полученные данные свидетельствуют о том, что рецидивы обусловлены не только техническими аспектами вмешательства, но и системной нестабильностью тазового дна. Комплексная оценка анатомических и функциональных параметров является ключевым условием выбора оптимальной хирургической тактики.

Ключевые слова: ректоцеле; цистоуретроцеле; пролапс тазовых органов; хирургическое лечение; леваторопластика; сетчатые импланты; рецидив; реконструктивная хирургия