



# Comments on: factors predicting the presence of concomitant enterocele and rectocele in female patients with external rectal prolapse

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To the editor,

We have read the article written by Tsunoda et al. [1], who suggests the use of evacuation proctography to identify the association of enterocele, rectocele, perineal descent, and pelvic organ prolapse in female patients with external rectal prolapse (ERP), discussing the importance of an adequate pelvic floor evaluation in the surgical treatment planning.

We have performed echodefecography modified from the technique described by Murad-Regadas et al. [2] to evaluate patients with obstructed defecation, which has proven to detect the same anorectal dysfunctions observed in defecography [2, 3]. In favor of this experience, our comments highlight the benefits this technique might offer to overcome proctography limitations and some technical tips to improve the diagnostic performance.

First, while traditional defecography is still the gold standard for evaluating functional anorectal disorders, the benefits are limited by the need for a specific radiological setting, the radiation exposure of patients, and an inability to show all anatomical structures involved in defecation. We can also include the patient's discomfort by an improvised evacuation setting plus the sensation of a synthetic stool inserted into the rectum and the additional vaginal contrast. Echodefecography is a 3-dimensional dynamic ultrasound (3DUS) technique developed to overcome these limitations [2]; it consists of 3 scans performed in lateral decubitus, an initial scan to evaluate the anatomical anorectal elements, a second scan in resting after the introduction of 120 to 160 mL of intrarectal ul-

trasound gel and a final scan for the functional assessment taken from the maximal straining during defecation. Findings in the rectovaginal wall evaluation can correspond to a hernia of the anterior wall of the rectum filled with ultrasound gel by drawing 2 parallel horizontal lines adjacent to the posterior vaginal wall, 1 in the initial straining position, and 1 at the point of maximal straining. Rectocele can be classified according to the distance between these 2 vaginal wall positions: grade I, 2–6 mm; grade II, >6–12 mm; and grade III, >12 mm [4]. In the same scan, rectal intussusception can be identified as an invagination of the anterior or posterior layers of the rectal mucosa, and intestinal loops can be found between the vagina and rectum wall detecting enterocele during the defecation straining [4-6]. We have performed the technique with 2 scans for better timing and patient comfort, with an initial resting scan after injection of the ultrasound gel into the rectum for evaluation of the anatomical pelvic structures and a second scan during sustained straining to identify the depth of rectocele, intussusception, sigmoidocele or enterocele and cystocele by displacement of the bladder neck under the puborectalis muscle.

Second, although echodefecography does not evaluate the degree of perineal descent, a displacement of the proximal border of puborectalis >2.5 cm can determine an excessive descent of the pelvic floor [3]. For complimentary evaluation, we can switch to the same transducer to 3DUS endovaginal modality introduced above the bladder neck, this reliable technique that allows its identification when there is a displacement of the anorectal junction >1 cm or it is positioned below the pubic symphysis during Valsalva maneuver [5], and also being able to identify defects on the levator ani (puborectalis and pubococcygeus muscle). [3] Given this, we can safely include anorectal and endovaginal dynamic ultrasound modalities as preoperative diagnostic tools in centers where 3DUD is available to identify the association between anatomical and functional pelvic anomalies in patients with ERP and its possible influence on the choice of the surgical procedure.

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Third, we coincided with the authors' statement that patients must have a satisfactory sphincter mechanism to increase the intrarectal pressure during straining to identify the rectocele during proctography accurately [6]. For this matter, 3DUS offers the benefit of allowing the examiner intervention during the study to avoid the escape of ultrasound gel during maximum straining, covering the perineum with the freehand to improve the identification of the rectocele and enterocele.

Once again, we congratulate the authors for their publication.

### CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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