

Renal Cell Carcinoma

Learn More About Advanced RCC and Available Treatment Options.

Cystocele or Rectocele

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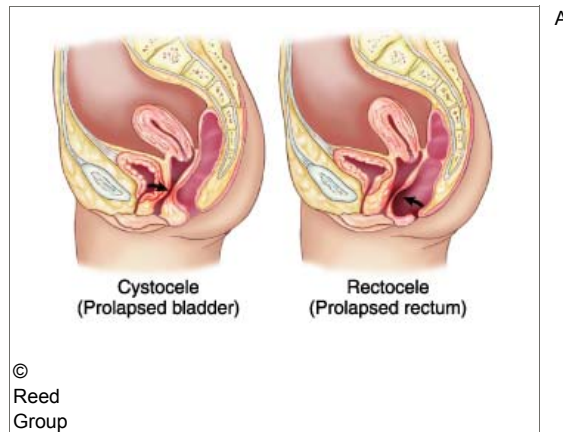


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Medical Codes

ICD-9-CM: 618.01, 618.02, 618.04, 618.2, 618.3, 618.4

Overview



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cystocele is herniation of the urinary bladder against the front (anterior) vaginal wall, and protrusion into the vaginal opening or vaginal canal. A cystocele occurs when the fibrous connecting tissues (fascia) separating the bladder and vagina weaken, resulting in bulging of the bladder into the vagina. Other portions of the urinary tract (e.g., the urethra) may also slip out of place (prolapse), but this may or may not cause symptoms to develop. A cystocele is considered grade 1 when the bladder protrudes only to the upper (internal) vagina; in grade 2, the bladder reaches the vaginal opening; and in grade 3, the bladder bulges directly through the vaginal opening.

A rectocele is a herniation of the last segment of the large intestine (rectum) against the back (posterior) wall of the vagina and protrusion into the vaginal opening or vaginal canal. A rectocele occurs when the muscles between the rectum and the vagina become weak from childbearing, old age, or surgery (e.g., hysterectomy), resulting in relaxation of rectal support structures, herniation of the rectum, and protrusion of the rectum into the vagina. It is not a defect of the rectum itself but of the connective tissue between the rectum and vagina (rectovaginal septum). The condition may also reflect a weakness present in the rectal wall since birth (congenital). In severe cases, rectocele may result in painful intercourse (dyspareunia) and difficulty defecating.

Most cases result from a history of multiple vaginal births, and steady increases in intra-abdominal pressure, regardless of the source of pressure. Although some degree of cystocele may be present after childbirth, it can worsen at menopause from a

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Factors Influencing Duration

Disability will be lengthened if corrective surgery is performed. Its duration will depend on job requirements, especially if heavy work and lifting is a job requirement. Age and health status also are factors influencing recovery time. Heavy lifting is usually prohibited after cystocele repair to decrease the chances of a recurrent cystocele.

Related Terms

- Cystic Hernia
- Cystourethrocele
- Female Urethrocele
- Pelvic Relaxation Syndromes
- Vaginal Prolapse

AdChoices

[▶ Cystocele](#)

[▶ Prognosis](#)

Differential Diagnosis

- [Bladder infection](#)
- [Bladder tumors](#)
- Enlargement of the uterus by [fibroids](#)
- Large urethral herniation

AdChoices

[▶ Prolapse Treatment](#)

[▶ Prolapse Surgery](#)

Specialists

- Gynecologist
- Urologist

AdChoices

[▶ Bladder Prolapse](#)

[▶ Bladder Dropped](#)

Comorbid Conditions

- Constipation
- Obesity

decrease in the female hormone estrogen, which causes relaxation of the muscles and tissues around the vagina and bladder.

Incidence and Prevalence: It is estimated that annually there are more than 200,000 surgeries for pelvic organ prolapse, which includes cystoceles, rectoceles, urethroceles (prolapse of the urethra), or combinations of these as in cystourethroceles (Shaw). In a study of 149,544 women, a lifetime risk of 11.1% was shown for surgery for pelvic organ prolapse and urinary incontinence (Shaw). Incidence of pelvic organ prolapse is increasing generally; an increase of 45% has been estimated for the second decade of the twenty-first century (Shaw).

Source: Medical Disability Advisor

Causation and Known Risk Factors

Pelvic organ prolapse increases with age, number of pregnancies, and vaginal births; however, rectocele can occur in women who have not been pregnant or given birth (Shaw).

Source: Medical Disability Advisor

Diagnosis

History: A cystocele or rectocele may or may not be symptomatic. The individual may report a sensation of vaginal fullness or pressure, the feeling that something is falling out, a feeling that the bladder does not completely empty, increased urinary frequency, the need to push the bladder up in order to urinate, or the feeling of a mass bulging into the vagina. Physical activity (heavy lifting), prolonged standing, coughing, sneezing, or straining can aggravate symptoms. If there is a cystocele, or if the urethra has been pushed out of position, the individual may leak urine when coughing, laughing, or lifting a heavy object (**stress incontinence**). A rectocele may cause constipation and incomplete defecation because of diminished muscle contractions in the rectum. The individual also may report having to manually push in (reduce) the rectocele before defecating. Painful intercourse also may be reported.

Physical exam: A doctor may be able to diagnose a grade 2 or grade 3 cystocele from a description of the symptoms and physical examination of the vagina. The fallen part of the bladder may be visible upon examination of the vagina; a smooth, bulging mass will be seen below the level of the cervix. The examiner may press a speculum against the vaginal side walls and ask the individual to strain, which allows the cystocele to be seen bulging into the anterior vaginal wall. Bearing down or straining moves the mass even farther into the vagina. Visual examination may also reveal a bulging of the rectum into the vagina (rectocele). While the individual lies flat with knees up (lithotomy position), the examiner may ask her to strain, making the rectocele visible and palpable when the vagina and rectum are examined manually. The examination will also assess the bladder position and urinary incontinence.

The American Urogynecological Society and the International Continence Society have devised a 9-point examination (Pelvic Organ Prolapse Quantitation) using 9 measurements of 6 topographical points on the vaginal wall, 2 points on the perineum, and the vaginal length (Shaw). This is an accepted standard exam that evaluates all parts of the vagina and allows identification of cystocele, rectocele, urethrocele, and prolapse of the small intestine into the vagina (enterocele).

Tests: Testing involves evaluating bladder and rectal function and performing imaging studies to identify anatomical defects. Pelvic floor fluoroscopy measures perineal descent, helping to determine which organ has herniated into the vagina: it is especially useful if problems with defecation have been reported. Magnetic resonance imaging (**MRI**) can reveal similar information, and has the added advantage of allowing

visualization soft tissue of the pelvic floor in greater detail. Rectoceles can be identified by proctograms (proctography). Colorectal transport of bowel contents can be examined with a colonic transit study using radiopaque markers taken orally and a series of x-rays taken over several days. Discovering a motility disorder or obstruction may also help explain rectum prolapse and rectocele. Women with defecation problems may also be evaluated by [colonoscopy](#).

Urodynamic testing is performed if incontinence accompanies pelvic organ prolapse. This testing involves taking [x-rays](#) of the bladder during urination (voiding cystourethrogram) to reveal the shape of the bladder and problems that might block the normal flow of urine. Other x-rays and tests, including a fluoroscopic examination (cinefluorography) while voiding, may be needed to rule out bladder abnormalities and other problems in the urinary system. Cystometry measures bladder capacity and control. A uroflowmeter analyses the urine flow.

Source: [Medical Disability Advisor](#)

Treatment

Treatment options range from no treatment for a mild cystocele to surgery for a serious cystocele. Kegel pelvic floor muscle strengthening exercises will be recommended, and are sometimes the only initial treatment. The physician or a physical therapist can help train the individual to contract the pubococcygeus muscle; this is best accomplished by asking the woman to practice the action of attempting to hold in urine. Some individuals who are not able to exercise the correct muscle may be advised to use weighted vaginal cones, biofeedback devices, or electrical stimulation to cause the correct muscle to contract.

A mild cystocele that may be bothersome can be treated with a device called a pessary. It is inserted into the vagina to support the vaginal walls, provide pelvic support, and hold the bladder in place. Pessaries come in a variety of shapes and sizes to allow for a comfortable fit. This can be a temporary management option, or in the case of older individuals who are not candidates for surgery, the treatment of choice. Pessaries must be removed regularly to avoid [infection](#) and prevent ulcers from developing. Estrogen replacement therapy (ERT) may be recommended for postmenopausal women. This can help strengthen the muscles around the bladder and vagina, and can be used alone, with a pessary, or before and after surgery. The individual should be told of the advantages and risks of taking estrogen.

Surgery is typically performed in women whose symptoms do not resolve after nonsurgical (conservative) treatment. Large cystoceles or rectoceles may require surgical repair to move the bladder back, suspending it into a more normal position (Burch colposuspension), permitting better bladder control and a more active lifestyle. Surgical repair of the vagina (anterior colporrhaphy) is done in women who do not plan to have more pregnancies. Urinary incontinence sometimes is also treated during colporrhaphy. The surgery stabilizes the bladder and can be performed through the vagina if the defect is midline; with transverse or paravaginal cystocele, a laparoscopic repair may be done. Posterior colporrhaphy is the surgical treatment for rectocele; the procedure involves repair of breaks or tears in the tissue between the vagina and rectum (rectovaginal septum). Another type of surgery (perineorrhaphy) shortens and tightens the perineum.

Prosthetic mesh (a "sling") may be inserted to further support the bladder during repair of a cystocele.

Source: [Medical Disability Advisor](#)

Prognosis

If nonsurgical treatment with exercises, a pessary, or other supportive device is chosen, the outcome may be good, but may provide only temporary improvement in some cases. The prognosis after surgery is excellent as long as the individual avoids conditions or activities that increase pressure in the pelvic and rectal area. Painful intercourse may occur if the repair is made too tight.

Source: [Medical Disability Advisor](#)

Rehabilitation

Pelvic floor exercises (Kegel exercises) may help strengthen the muscles of the vagina and those between the rectum and vagina. These isometric exercises involve contraction of the pubococcygeus muscle; it is difficult for some individuals, and instruction or the use of weighted vaginal cones may be needed to help individuals contract the right muscle.

Source: [Medical Disability Advisor](#)

Complications

A large cystocele can cause stress incontinence when the individual sneezes, coughs, laughs, lifts, or does anything that puts pressure on the bladder. It also may cause incomplete emptying of the bladder leading to recurrent urinary tract infections. The uterus also can drop from its normal position into the vagina (uterine prolapse). This often is associated with a cystocele because of the weakened vaginal tissue. Removal of the uterus ([hysterectomy](#)) may need to be done at the same time as the repair of a cystocele or rectocele.

Source: [Medical Disability Advisor](#)

Ability to Work (Return to Work Considerations)

Heavy lifting or straining can cause the cystocele or rectocele to worsen and should be avoided. Several days in the hospital and 4 to 6 weeks of recuperation should be expected for a full return to normal function after surgery. The individual can return to work after treatment but should continue to avoid heavy lifting, straining, and prolonged standing. Women who repetitively lift greater than 50 pounds put their repairs at risk, and most urologists/OB-GYNs limit lifting permanently to 50 pounds after this surgery.

Source: [Medical Disability Advisor](#)

Failure to Recover

If an individual fails to recover within the expected maximum duration period, the reader may wish to consider the following questions to better understand the specifics of an individual's medical case.

Regarding diagnosis:

- Did individual present with symptoms of pelvic organ prolapsed?
- Was there a history of pregnancy(ies) and vaginal birth(s)?
- Were imaging studies done to evaluate bladder and rectal function?
- Was proctography done to assess for rectocele?
- Was diagnosis of cystocele or rectocele confirmed?
- Were other bladder or uterine abnormalities considered and ruled out?
- Was urodynamic testing done to evaluate incontinence?
- Has individual experienced any complications associated with the cystocele or rectocele, such as stress incontinence, recurrent urinary tract infections, or uterine prolapse?

- Does individual have coexisting conditions, such as obesity and constipation that affect the weight and pressure on the muscles, and could worsen the condition?
- Does individual have job that requires repeated heavy lifting or straining?

Regarding treatment:

- Were pelvic floor exercises (Kegel exercises) recommended as an initial treatment measure to help strengthen muscles of the vagina and those between the rectum and vagina?
- Did individual receive instruction in Kegel exercises? Has individual been compliant with recommended exercises?
- Is additional or alternate therapy needed such as biofeedback, vaginal cones, or electrical stimulation?
- If treatment was by pessary, was it chosen as a temporary management option, or because individual was not a candidate for surgery? If for temporary management, what further treatment will be required?
- If postmenopausal, was estrogen replacement therapy (ERT) considered to help strengthen muscles around the bladder and vagina? Was individual informed of the advantages and risks of taking estrogen?
- Was anterior colporrhaphy done? Vaginally or laparoscopically?
- Was surgical repair successful in moving the bladder back into a more normal position? Was better bladder control achieved? Is further therapy anticipated?

Regarding prognosis:

- If treated nonsurgically with Kegel exercises or pessary, does individual understand that although the outcome may be good, this may be only a temporary improvement?
- Following surgical correction, does individual understand that she must avoid conditions or activities that produce a major increase in pressure in the pelvic and rectal area?
- Was individual instructed in proper ergonomics for lifting heavier objects, and about permanently limiting lifting to 50 pounds or less after cystocele surgery?
- Have symptoms recurred? Are additional or alternate treatment options being considered?

Source: [Medical Disability Advisor](#)

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General

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Source: [Medical Disability Advisor](#)

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