



# Stop, Drop, and Roll: One Woman's Pelvic Floor Disease Journey

David Lehoang, MD<sup>1</sup>, Sean Dewberry, BS<sup>2</sup>, Niharika Mallepally, MD, MPH<sup>3</sup>, Christine Hsieh, MD<sup>4</sup>, Sonia Sharma, MD<sup>3</sup>  
Keck School of Medicine<sup>2</sup>, <sup>1</sup>Department of Internal Medicine, <sup>3</sup>Department of Gastroenterology, <sup>4</sup>Department of Colon and Rectal Surgery, Los Angeles, CA, USA

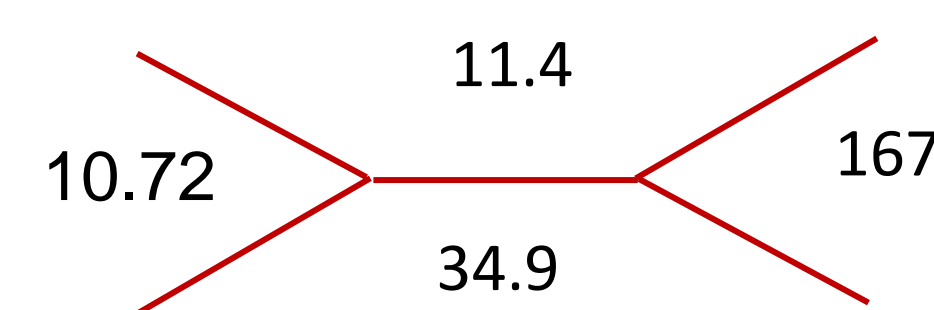


## Background

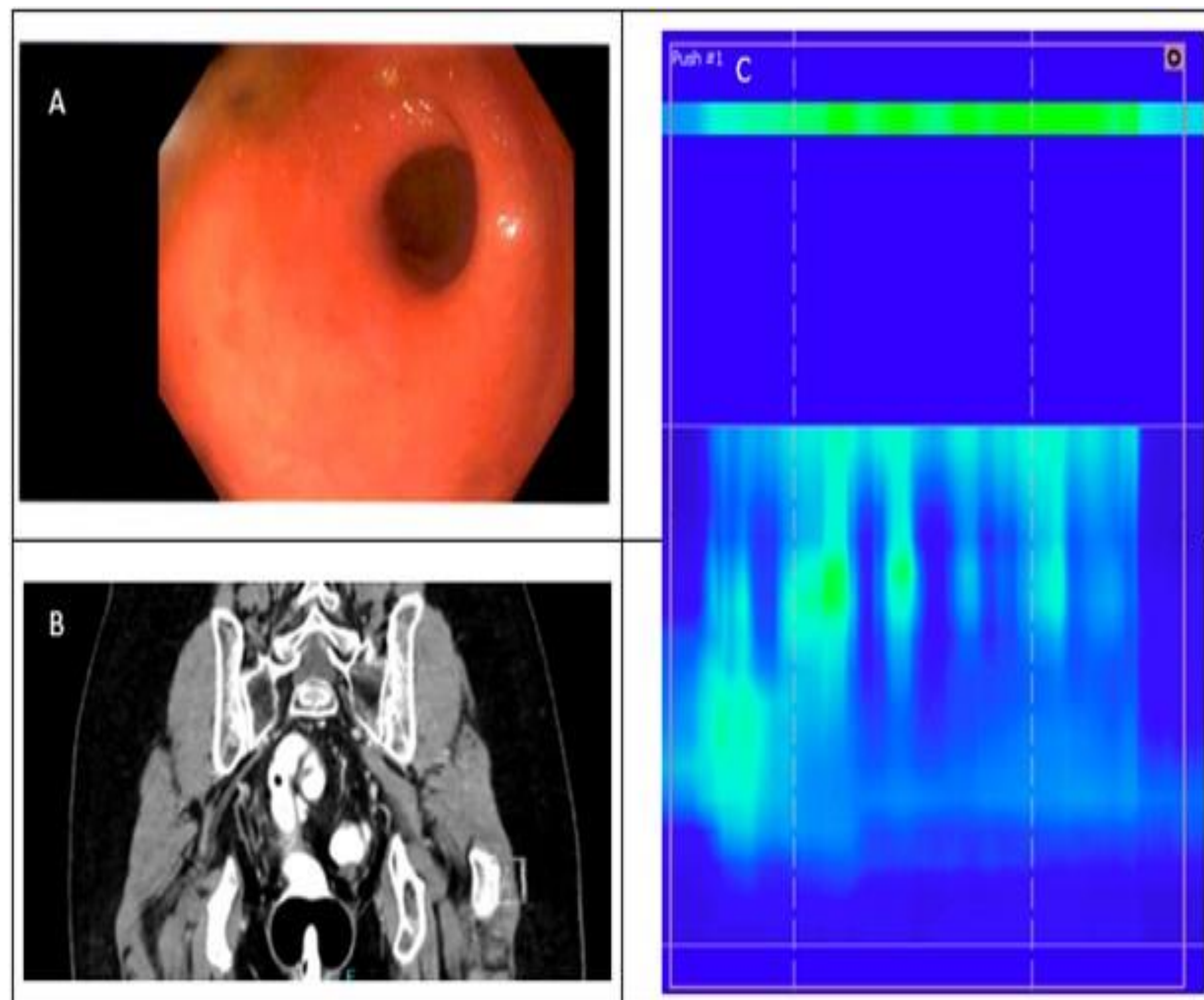
- Pelvic floor disease includes symptoms of the anterior (urinary, vaginal) and posterior (anorectal) pelvic floor.
- This case describes a woman who developed dyssynergic defecation after surgical management of urinary incontinence.

## Clinical Course

- 69-year-old woman presenting with bloating and difficulty defecating for 2 years.
- Admission CBC unremarkable
- Two years ago, she underwent sacrocolpopexy and mesh placement to treat pelvic organ prolapse. Her urinary incontinence improved but constipation worsened.
- Anorectal manometry (ARM) showed dyssynergic defecation and unsuccessful balloon expulsion, consistent with mechanical obstruction (Image C).
- A flexible sigmoidoscopy showed benign-appearing extrinsic compression at the rectosigmoid junction.
- Given a concern for mass effect of the mesh into the colon, an exploratory laparoscopy was performed, showing a redundant SC with scarred, edematous mesentery.
- A partial sigmoidectomy was performed and adhesions at the anterior rectal wall (near the sacrocolpopexy mesh) were lysed. In just 3 months, the patient's symptoms resolved (Image A).



## Images



- A. Flexible sigmoidoscopy: Very narrowed lumen in the sigmoid colon.
- B. CT abdomen and pelvis: Coronal view showing sharp angulation in the sigmoid colon (due to the mass effect of the mesh and adhesions).
- C. Anorectal manometry: The Y-axis notes length (cm) from anal sphincter (0 cm) into sigmoid. The X-axis shows time (in seconds). The color of the data points denotes pressure exerted. Here, the top horizontal line in green shows rectal pressure. The same amount of pressure is shown in the bottom "green" areas, indicating that anal tone failed to appropriately relax. This increase in anal pressure with a good push indicates a dyssynergic defecation pattern.

## Discussion

- Postoperative adhesions are present after 63-97% of open abdominal surgeries.
- Most common complication of such adhesions is bowel obstruction, occurring in 15% of patients within 1 month of surgery.
- Our patient had an even more unique complication: constipation and dyssynergic defecation.
- Literature on post-op adhesions and defecation dysfunction mainly describes surgery of the rectal sphincter. In contrast, the sacrocolpopexy did not involve the rectum or surrounding peritoneum but caused adhesions with a mass effect on the rectum.
- Given the morbidity associated with lower abdominal adhesions, suspicion must remain high in populations with a history of complicated abdominal surgery, especially for treatment of anterior pelvic floor disease.

## References

1. Arung W, Meurisse M, Detry O. Pathophysiology and prevention of postoperative peritoneal adhesions. *World J Gastroenterol.* 2011;17(41):4545-4553. doi:10.3748/wjg.v17.i41.4545
2. Keane C, Fearnhead NS, Bordeianou LG, Christensen P, Basany EE, Laurberg S, Mellgren A, Messick C, Orangio GR, Verjee A, Wing K, Bissett I; LARS International Collaborative Group. International Consensus Definition of Low Anterior Resection Syndrome. *Dis Colon Rectum.* 2020 Mar;63(3):274-284. doi: 10.1097/DCR.0000000000001583. PMID: 32032141; PMCID: PMC7034376.
3. Okabayashi K, Ashrafian H, Zacharakis E, Hasegawa H, Kitagawa Y, Athanasiou T, Darzi A. Adhesions after abdominal surgery: a systematic review of the incidence, distribution and severity. *Surg Today.* 2014 Mar;44(3):405-20. doi: 10.1007/s00595-013-0591-8. Epub 2013 May 9. PMID: 23657643.
4. Zieliński T, Czyżewski P, Szczepkowski M. The usefulness of anorectal manometry in patients with a stoma before and after surgery to restore the continuity of the gastrointestinal tract. *Pol Przegl Chir.* 2016 Jan 1;88(1):1-6. doi: 10.1515/pjs-2016-0019. PMID: 27096767.