Tripartite Congress

Groupement européen de périnéologie

Groupement Européen de Périnéologie

Mediterranean Society of Coloproctology

MSPFD

Mediterranean Society of Pelvic Floor Disorders

Sharm El - Sheikh

Egypt

March 25 - 27

2004

Final Program

State of art
09:00-09:30

Chairman: Mauro Cervigni

Levatorplasty according to Shafik: a basic procedure in perineology.
Jacques Beco (Belgium, Gynecology)

Scientific Session (4)
Chronic Pelvic Pain
09:30-11:00

Chairman: Samir El-Sahwi
Moderator: Els Bakker

Anatomy of the pudendal nerve: facts and controversies.
Jacques Beco *(Belgium, Gynecology)*

Sacral neuromodulation in chronic pelvic pain.
Ezio Ganio *(Italy, Surgery)*

New approach for treatment of pudendal nerve entrapment: 406 cases and 171 decompressions.
Eric Bautrant Eric *(France, Gynecology)*

Laparoscopic management of chronic pelvic Pain.
Samir El-Sahwi *(Egypt, Gynecology)*

Pudendal neuralgia: nerve compression or radiculopathy?
Eric de Bisshop *(France, Electrophysiology)*

Effect of coccyx manipulation on coccygodynia, urinary and anorectal functional troubles.
Georges Nélissen *(Belgium, Osteopathy)*

Chronic pelvic pain and interstitial cystitis.
Mauro Cervigni *(Italy, Gynecology)*

Physical therapy for pelvic floor dysfunction.
Gamil El- Hanak *(Egypt, Physiotherapy)*

11:30 -12:00 **Coffee Break**

Odds Ratio of being incontinent
6 weeks 4 months
OR p OR P
Poor PFM vs normal 3,79 0,009 0,26 0,576
Age > 65 1,88 0,002 4,05 0,000
Urodynamic abnormalities 1,50 0,161 0,68 0,286
PFM < 0,8 cm 2,75 0,108 0,63 0,503

Post RP continence is achieved in most patients in 6 weeks to 4 months. The age is the most important predicator of incontinence. The pelvic floor mobility and some urodynamic abnormalities are other indicators of a high risk of incontinence.

Dynamic MRI in Female Pelvic Floor Dysfunction

Rania Farouk
(Egypt, Radiology)

Levatorplasty according to Shafik: a basic procedure in Perineology?

Jacques Beco M.D. (*), Jack Mouchel M.D (**)
(France) (Belgium, Gynecology)

Levatorplasty has been described by Shafik in the treatment of rectal prolapse (1). For this author dyschesia (or strainodynia) and rectal prolapse are often the result of a sagging of the levator plate associated with a subluxation of the hiatal ligament which connect the rectal neck to the edges of this plate.In a normal defecation, this link is very important to open the rectal neck and to prevent the abdominal pressure to squeeze the anal canal. The aim of levatorplasty is to restore the rectal neck-levator link and the ano-rectal angle by doing a posterior levator myoraphy with stitches between the rectal neck and the muscle.

The literature about this operation is very poor. A posterior levator myoraphy was performed during post-anal repair but this operation was done through the sphincter and was indicated in case of anal incontinence.

In the GEP's experience this operation was done through a sagittal incision between anus and coccyx (the original incision described by Shafik was U-shapped).We use this procedure in the treatment of genital prolapse, if the patient presents an embarrassing dyschesia (strainodynia) or if an overload pain was discovered by the anti-sagging manoeuvre (2). We don't have any experience with this operation in the treatment of rectal prolapsed.

We performed 76 levatorplasties (63 in Belgium and 13 in France) between march 2000 and December 2003 (mean age = 52,2 ans, extr. 29-79) 48 patients were reviewed one year after the operation. On the 35 patients presenting dyschesia before the operation 28 (80%) were cured or improved. In the 3 cases of overload pain, the pain was cured 1 time and seriously reduced in the 2 other cases. Perineometry at rest and during Valsalva manoeuvre revealed an objective effect of levatorplasty on the anus position(n=26, mean ascension one year after: at rest = 0.58 cm and during Vasalva = 1.28 cm).

Post-anal levator plate (LP) ultrasonography revealed a reduction of the sagging of the levator plate (n= 10, mean reduction one year after: at rest = 9,57 degrees; during Valsalva = 16 degrees). The complications observed were 4 severe ischio-rectal fosse infections and 1 hypertrophic and painful scar.

Conclusion: levatorplasty according to Shafik with a modification of the skin incision should become one of the basic procedures in Perineology.This operation can cure dyschesia and pain by overload of the structures of suspension.Because the levator sagging is significantly reduced by the operation it acts on one of the causes of genital and rectal prolapse. Unfortunately, the risk of infection of the ischio-rectal fossae in this study was quite high (5%). This risk must be reduced and the follow up has to be longer before to introduce this surgical procedure in the routine.

Pudendal Nerve Anatomy: Facts and Controversies

Jacques Beco M.D.
Belgium

According to the literature and our dissections the anatomy of the pudendal nerve could be described as follow. The pudendal nerve is a mixed nerve carrying motor and sensory fibers. Its fibers are derived from the sacral roots S2,S3 and S4 (1,2).

References:

1. Shafik
A new concept of the anatomy of the anal sphincter mechanism and the physiology of defaecation. XXVIII – Complete rectal prolapse: a technique for repair.
Colo-proctology, 6, 1987, 345-352.

2. Beco J., Mouchel J.
Post-anal ultrasound of the levator plate and ultrasound of the pubo-rectalis in the management of a painful puborectalis. Case report. 4th International Pelvic Floor Dysfunction Society Congress, Taormina (Italy), March 13-16, 2002
http://www.perineology.com/files/taormina_case.htm