Response to letter to editor: “Pelvic floor imaging with MR defecography: correlation with gynecologic pelvic organ prolapse quantification by Swamy et al.”

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To the editor,

We thank and appreciate the comments of Dr. Guerra and colleagues regarding our study. We agree that magnetic resonance defecography (MRD) plays an invaluable and complimentary role to clinical examination of women with pelvic prolapse.

Dr. Guerra and colleagues stated that in their experience with posterior compartment dysfunction, they found three main imaging findings which are difficult to identify or even undetectable on physical examination: (a) the presence of hypertrophy of the puborectal muscle with indentation of the posterior wall of the rectum, (b) the presence of anterior rectocele, and (c) the paradoxical muscular contraction of the pelvic floor or anismus, represented by the measurement of the anorectal angle.

As stated in our article [1], in the clinical pelvic organ quantification (POP-Q) system, the posterior vaginal wall situs is identified by measurement “Bp”, which measures the most distal or dependent point of the posterior vaginal wall. Any alteration in the position of the posterior vaginal wall (whether it is from an anterior rectocele or cul-de-sac hernia) will be clinically perceived as an abnormal Bp measurement but is however nonspecific. MRD thus has the distinct advantage of discerning the exact etiology for the posterior vaginal bulge and more accurately depicting an

anterior rectocele vs contents of a cul-de-sac hernia, both of which have different surgical implications.

The remaining two imaging findings in posterior compartment dysfunction mentioned by Dr. Guerra and colleagues, namely puborectalis muscle hypertrophy and paradoxical puborectalis contraction are also demonstrated by manometry and defecography [2]. However, as they rightly stated, these two pathologies are causes of posterior compartment dysfunction, not pelvic prolapse, and hence were not a consideration in our article. Morphological or functional puborectalis dysfunction can certainly co-exist with prolapse and their detection could potentially alter management.

Dr. Guerra and colleagues make good points regarding evaluation of pelvic floor dysfunction in men. In our center, we are rarely referred male patients for pelvic prolapse, although we have imaged a few male patients referred for spastic pelvic floor syndrome. There certainly is a paucity of published literature in this group of patients and more studies would be beneficial.

References

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