

RESEARCH ARTICLE

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Role of conventional radiology and MRI defecography of pelvic floor hernias

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Abstract

Background: Purpose of the study is to define the role of conventional radiology and MRI in the evaluation of pelvic floor hernias in female pelvic floor disorders.

Methods: A MEDLINE and PubMed search was performed for journals before March 2013 with MeSH major terms 'MR Defecography' and 'pelvic floor hernias'.

Results: The prevalence of pelvic floor hernias at conventional radiology was higher if compared with that at MRI. Concerning the hernia content, there were significantly more enteroceles and sigmoidoceles on conventional radiology than on MRI, whereas, in relation to the hernia development modalities, the prevalence of elythroceles, edroceles, and Douglas' hernias at conventional radiology was significantly higher than that at MRI.

Conclusions: MRI shows lower sensitivity than conventional radiology in the detection of pelvic floor hernias development. The less-invasive MRI may have a role in a better evaluation of the entire pelvic anatomy and pelvic organ interaction especially in patients with multicompartamental defects, planned for surgery.

Introduction

Pelvic floor disorders represent a significant cause of morbidity and reduction in quality of life that appear to be increasing in frequency during the last few years [1]. Pregnancy, multiparity, advanced age, menopause, obesity, connective tissue disorders, smoking, chronic obstructive pulmonary disease, are only some of the risk factors that can rise intra abdominal pressure and cause these disorders [2].

Pelvic floor disorders may be associated, with an incidence ranging from 18% to 45%, to the so-called midline pelvic floor sagittal hernias (MPH) that represent the herniation of the peritoneum and/or peritoneal viscera in the Douglas', Retzius', and retrorectal spaces.

Although anamnestic and physical examination represents the first approach in the evaluation of the patients with pelvic floor dysfunction, the diagnostic limitation of

the pelvic examination alone has led to the need to use more direct and comprehensive diagnostic methods [3-6].

Purpose of the study is to define the role of conventional radiology and MRI in the evaluation of pelvic floor hernias.

Materials and methods

Subjects

A MEDLINE and PubMed search was performed for journals before March 2013 with MeSH major terms 'MR Defecography' and 'pelvic floor hernias'. Non-English speaking literature was excluded.

Methods

Conventional radiology

Entero-colpo-cysto-defecography (ECCD) is considered the gold standard for the evaluation of the patients with pelvic floor disorders and diagnosis of MPH [7-9]. For this exam no bowel preparation [10-13]. To obtain small-bowel contrast, 1 h before the exam, 200 mL of barium sulfate 60% p/v is administered to each patient. Through a

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catheter inserted in the bladder, 400 cc of iodine contrast medium (Ultravist, Bayer Schering Pharma, Berlin, Germany) is injected until the patient felt a sensation of fullness. The patient is placed in the left lateral decubitus position, after which 200 cc of barium paste (Prontobario Esofago 113%, barium paste, Bracco, Milan, Italy) was introduced into the rectum. During injector removal, the anal canal is also contrasted. Vagina is contrasted with 25 ml of barium paste. The fluoroscopic table is then tilted upright 90°, and the patient is seated on a radiolucent commode. An anteroposterior radiograph is taken with the patient at rest; after that, five lateral radiographs are taken at rest, during squeezing, pushing, evacuation, and after evacuation (Table 1).

Dynamic MR defecography

MRI Defecography should be performed on 1.5-T closed magnet using a body-phased-array receiver coil. To ensure an adequate bladder filling, all patients are invited to drink 500-700 ml of water 10-15 min before the examination. The rectum and vagina should be filled with 200 mL and about 25-30 mL [14], respectively, of a mixture of ultrasonographic gel (Ultragel, G.P.S., Bologna, Italy) and gadolinium-diethylenetriamine pentaacetic acid [3] (Table 1). The study protocol includes TSE T2-W axial (matrix, 181x256; slices, 25; thickness, 5 mm; TR/TE, 6,430/114; flip angle, 180°), TSE T1-W sagittal (matrix, 181x256; slices, 25; thickness, 5 mm; TR/TE, 846/11; flip angle, 150°) sequences, and functional dynamic sequences TRUFISP T2-W sagittal, during squeezing, pushing, and evacuation (matrix, 181x256; slices, 1; thickness, 8 mm; TR/TE, 3.75/ 1.6; flip angle, 80°) (Table 2). The MR-D images so obtained then are assembled in cineview in postprocessing. Examination time took about 30 min to complete.

Image analysis

The reference line used for conventional radiology and MRI is the Pubococcygeal line (PCL), extending from the most inferior portion of the symphysis pubis to the tangent of the sacrococcygeal joint.

The diagnosis of descent of the bladder, vagina, and rectum is based on measurement of the vertical

distance between the PCL and the bladder base, the vaginal vault, and the anorectal junction, respectively.

According to Yang’s classification [7], the limits of normal descent with maximal strain are 1.0 cm below the PCL for the bladder base, 1.0 cm above for the vaginal cuff or lower end of the cervix, and 2.5 cm below for the rectal area.

Pelvic floor hernia classification

Rectocele could be defined as an out-pouching of the anterior rectal wall occurring during evacuation or straining [15-17] (Figure 1a-b).

Pelvic floor hernias could be classified, basing on the content, into enterocele, omentocele, and sigmoidocele, whereas, according to the hernia development they could be classified as elythrocele, edrocele, retrorectal, and Douglas’ and Retzius’ hernias [6] (Figure 2a-b).

Enterocele, sigmoidocele, and omentocele represent the herniation below the proximal (apical) one third of the vagina of the peritoneal sac containing ileal loops, part of the sigmoid, or peritoneal fat, respectively [18-21]. If the small bowel, the peritoneal fat, or the sigmoid colon entered the Retzius’ or Douglas’ space, they are identified as Retzius’ and Douglas’ hernias, respectively; if they entered the vaginal fornix posteriorly, causing a complete eversion of the vaginal wall, an elythrocele is recognized (posterior vaginal hernia) [21,22] (Figure 3). In the same way, if they enter the rectum anteriorly, leading to a rectal wall eversion, an edrocele is detected [3,23-25] (Table 3)

Conventional radiology diagnosis

On evaluation of conventional radiology, the diagnosis of an enterocele/ sigmoidocele/omentocele is made if the picture obtained during evacuation compared with that during rest showed an increase in the distance between the vagina and rectum (Figure 4).

This expansion should extend below the PCL reference line and shows a sagittal diameter of more than 2 cm.

Anyway, the distinction between sigmoidocele, enterocele, and omentocele is made basing on the presence of contrasted small bowel in the expanded recto-vaginal space for the enterocele, on the presence of distinguishable bowel gas bubbles without contrast for the sigmoidocele alone, and on the absence of contrasted small bowel and bowel gas bubbles in the expanded recto-vaginal space, for the omentocele.[26-28]

Table 1 Conventional Radiology and MRI Defecography technique

	Conventional Radiology	MRI Defecography
Bladder	400 cc of iodine contrast medium	500-700 mL of water per os 10-15 min before
Vagina	25 ml of barium paste	25-30 mL of gadolinium-diethylenetriamine pentaacetic acid
Rectum	200 cc of barium paste	200 mL of a mixture of ultrasonographic gel
Acquisition	AP at rest, during squeezing, pushing, evacuation and after evacuation	TSE T2 ax, TSE T1 sag, TRUFISP T2 sag during squeezing, pushing, evacuation

Table 2 MRI defecography protocol

	TSE T2 ax	TSE T1 sag	TRUEFISP T2 sag*
Matrix	181x256	181x256	181x256
Slices	25	25	1
Thickness	5 mm	5 mm	8 mm
TR/TE	6.430/114	846/11	3.75/1.6
FA	180°	150°	80°

Mri defecography diagnosis

On MRI-defecography, the relationship between the lowest point of the peritoneal border line and the PCL should be assessed. A descent of parts of the peritoneal content below this line and the identification of herniated contents allowed the distinction in enterocele, sigmoidocele, and omentocele [8]. The hernias detectable only during pushing and evacuation are considered as “functional hernias.”

Results and discussion

In our experience, the specificity of MRI versus conventional radiology is of a 100%; the sensibility of MR-D in the detection of an omentocele, sigmoidocele, and enterocele is, respectively, 95%, 82%, and 65%, showing an inferior diagnostic capacity if compared with conventional radiology [29,30]. The prevalence of MPH ranged from 38% among all the enrolled patients to 51% in the patients reporting previous hysterectomy. These data are in agreement with the available literature and emphasize the role

of previous pelvic surgery in the genesis of MPH [24]. The most frequent hernia is enterocele (70%), followed by sigmoidocele (21%), and omentocele (9%). On the other hand, the most frequent hernia development modality is in Douglas’ space (78.9%), whereas the Retzius’ and retrorectal hernias represent only occasional findings. The development of the hernias in the posterior vaginal wall or in the anterior rectal wall is observed in 9% and 12% of cases, respectively. Despite their low prevalence, their detection is important in the planning of the correct therapeutic approach. Conventional radiology is currently considered as the gold standard [5,7,8], because is a cost-effective procedure, simple to perform, and widely available [19]; however, it is an invasive procedure, especially if it is performed with four contrast that uses ionizing radiation and visualizes only the lumen of the opacified organs. MRI Defecography was first described by Yang et al. in 1991 [7,31], is a less-invasive imaging modality that allows a multiplanar and multiparametric evaluation of the three pelvic compartments, also visualizing soft tissue, in a single procedure without exposure to ionizing radiation. After this, several studies were performed to compare the diagnostic efficacy of dynamic MRI defecography versus that of conventional radiology in a patient with pelvic floor disorders, with variable results [5, 8, 18, 20, 32-34]. In our experience, conventional radiology has higher sensitivity in detecting both the content and the developmnet of pelvic floor hernias if compared with dynamic MRI Defecography. However, the prevalence of enterocele, sigmoidocele, edrocele, elytrocele, and Douglas’ hernias at conventional

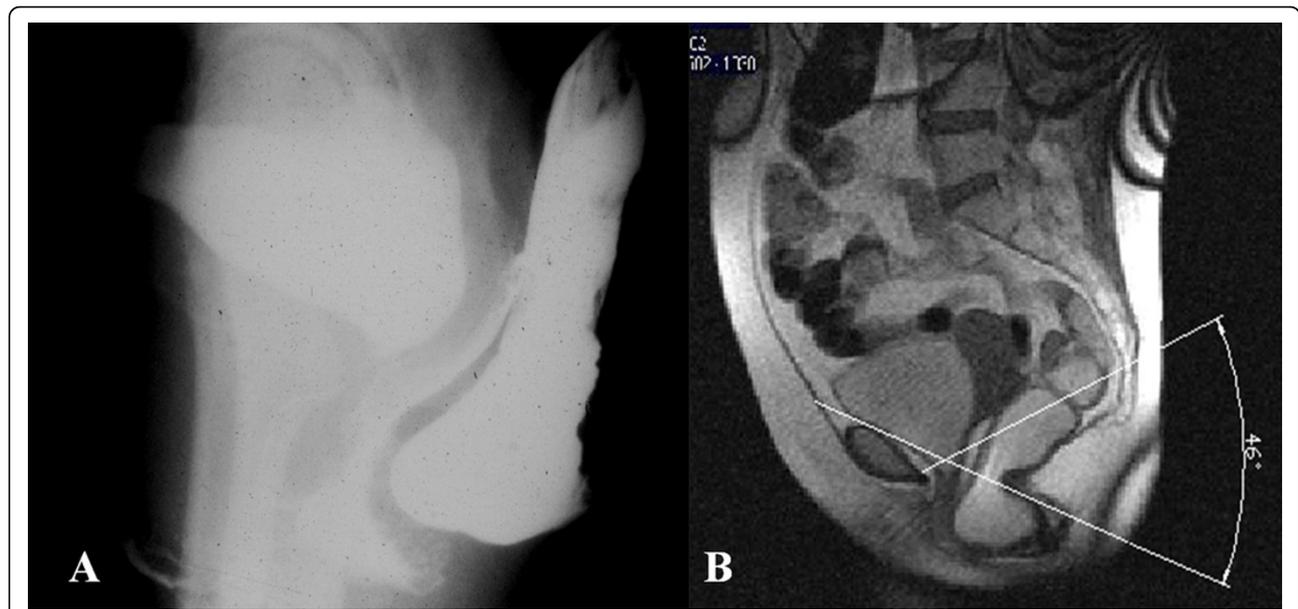


Figure 1 (a) Rectocele at ECCD defined as an out-pouching of the anterior rectal wall occurring during evacuation or straining, correctly identified also at MR-Defecography(b).

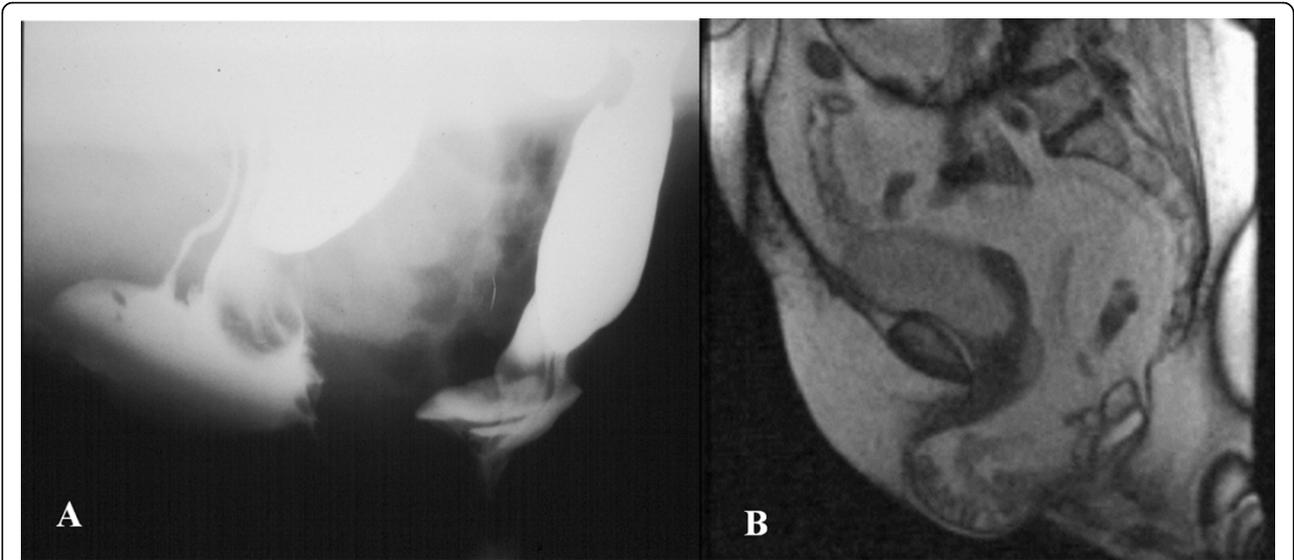


Figure 2 (a) Enterocoele at ECCD: correctly identified also at MR-Defecography(b).

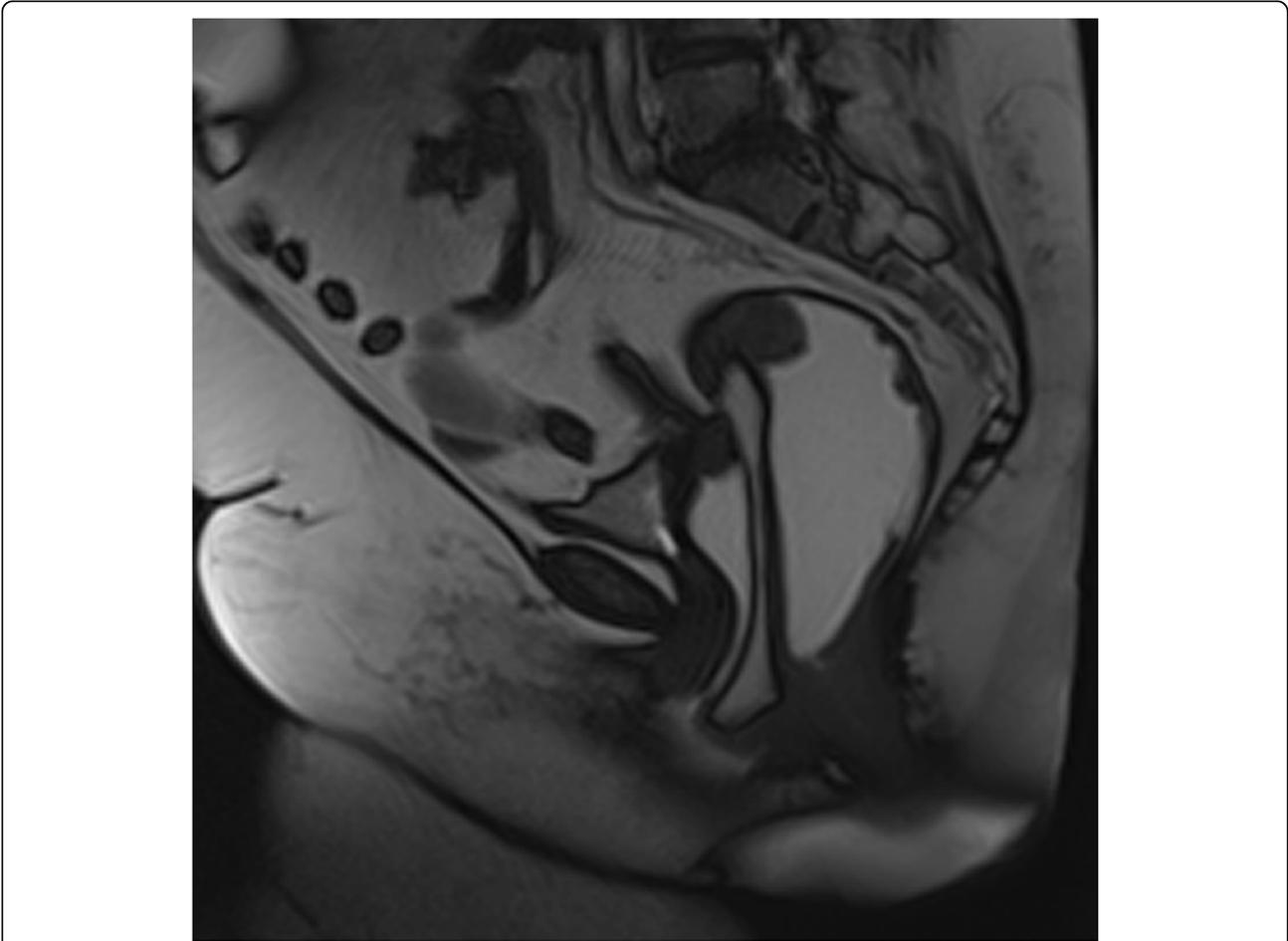


Figure 3 Omentocele at MR-Defecography: the MR-Defecography clarifies the hernia content as a omentocele.

Table 3 Classification of pelvic floor hernias

Content	Enteroceles Omentocele Sigmoidocele
Development	Elytrocele (posterior vaginal hernia) Edrocele (anterior rectal hernia) Retrorectal Douglas' hernia Retzius' hernia

radiology is significantly higher than at MRI Defecography. These findings, in accordance with other authors [5,20], emphasize the role of conventional radiology in the diagnosis of pelvic floor hernias in female pelvic floor disorders, whereas MRI defecography could be more useful to clarify the intra-pelvic interaction of multiple organ prolapse [33] and to better define the pelvic anatomy and functioning in patients planned for surgery [34,35]. Moreover, MRI defecography is a safe, noninvasive exam and free from ionizing radiation [32,36] that is able to correctly define the large bowel loop content of a retrorectal hernia, previously misdiagnosed as an enterocele at conventional radiology

[37-40]. The lower sensitivity of MRI Defecography in the detection of pelvic floor hernias may be related to the supine position of the patients [41] and defecation also plays a role by ensuring that intra-abdominal pressure is adequately elevated. A solution on MRI defecography is to repeatedly encourage patients to strain maximally or to monitor intra-abdominal pressure [20].

Conclusion

In conclusion, MRI defecography shows lower sensitivity than conventional radiology in the detection of pelvic floor hernias. The diagnostic efficacy of conventional radiology is significantly higher than that of MRI Defecography in the detection of both hernia content (enteroceles and sigmoidoceles) and hernia development (Douglas' hernia, elythroceles, and edroceles).

However, the less-invasive MRI defecography may have a role in a better evaluation of the entire pelvic anatomy and pelvic organ interaction especially in patients with multicompartmental defects, planned for surgery [42].

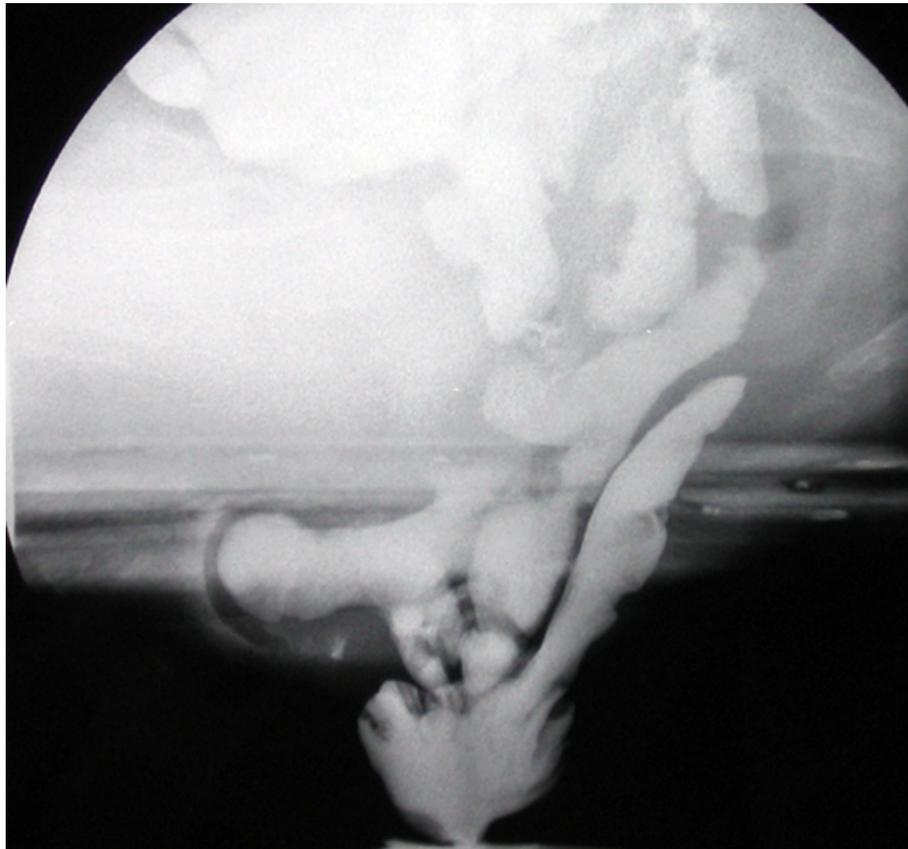


Figure 4 Elythroceles and Edrocele at ECCD: the small bowel loops enter the vaginal fornix posteriorly with an eversion of the vaginal posterior wall. And the rectum with an eversion of the rectal anterior wall.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

AR: conceived the study, analyzed and interpreted the data, drafted the manuscript.
GDG: conceived the study, critically revised the manuscript.
GG: critically revised the manuscript.
FI: critically revised the manuscript.
CR: critically revised the manuscript.
MG: analyzed the data and critically revised the manuscript.
FC: analyzed the data and critically revised the manuscript.
LB: conceived the study, analyzed and interpreted the data, critically revised the manuscript.
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