

Anatomy and surgical cure of descending perineal syndrome

Peter Petros

International Urogynecology Journal
Including Pelvic Floor Dysfunction

ISSN 0937-3462
Volume 29
Number 4

Int Urogynecol J (2018) 29:605-606
DOI 10.1007/s00192-018-3557-y



Your article is protected by copyright and all rights are held exclusively by The International Urogynecological Association. This e-offprint is for personal use only and shall not be self-archived in electronic repositories. If you wish to self-archive your article, please use the accepted manuscript version for posting on your own website. You may further deposit the accepted manuscript version in any repository, provided it is only made publicly available 12 months after official publication or later and provided acknowledgement is given to the original source of publication and a link is inserted to the published article on Springer's website. The link must be accompanied by the following text: "The final publication is available at link.springer.com".



Anatomy and surgical cure of descending perineal syndrome

Peter Petros¹

Received: 11 May 2017 / Accepted: 4 January 2018 / Published online: 6 February 2018
© The International Urogynecological Association 2018

Anatomy

With reference to Chaudhry and Tarnay [1], we refer IUJ readers to the study on the anatomy and surgical repair of the descending perineal syndrome [2]. Live dissection was performed in 30 Caucasian female patients, who presented with manually assisted defecation and a low rectocele consistent with descending perineal syndrome. It was demonstrated that the perineal body was divided into two parts, joined by a stretched central part, anchored laterally by the deep

transverse perinei ligaments (Fig. 1). These inserted behind the descending ramus of the pubic bone at the junction of the upper two thirds and lower one third (Fig. 1, left). The deep transverse perinei (DTP) is anatomically classified as a muscle, but histological examination indicated that it was similar to other pelvic ligaments, being composed of collagen elastin, smooth muscle, nerves and blood vessels, with only small amounts of striated muscle. The mean longitudinal length of the perineal body was 4.5 (3.5–5.5) cm, accounting for 50% of the posterior vaginal support.

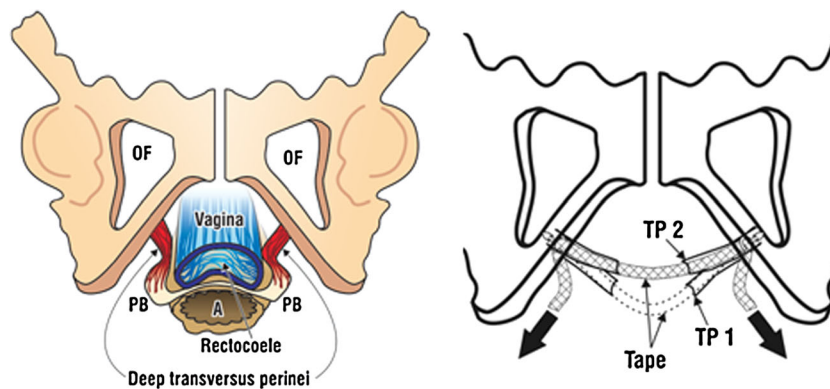


Fig. 1 *Left:* anatomy. Schematic view of the components of a perineal body in patients with descending perineal syndrome. The perineal bodies (PB) and their attachments to the descending ramus and deep transverse perinei have been displaced downward and laterally. The central part of the perineal body is stretched and thinned. The rectum everts forward to cause low and mid rectocele. The *arrows* indicate the attachment of the deep transverse perineal ligament to the posterior surface of the descending ramus exactly at the junction of the upper two thirds and

lower one third. *OF* obturator foramen, *A* anus. *Right:* surgery. Schematic view of repair of prolapsed and laterally separated perineal bodies. The perineal bodies are elevated and approximated by the one-way tensioning action of the tissue fixation system sling. *TP1* prolapsed deep transverse perineal muscles attached to posterior surface of the descending ramus of the pubis. *TP2* is the restored position of the deep transverse perineal muscle. The tape is inserted through the deep transverse perinei behind the descending ramus

✉ Peter Petros
pp@kvinno.com

¹ University of NSW, Professorial Department of Surgery, St Vincent's Hospital Sydney, Sydney, Australia

Surgery

A transverse incision was made proximal to the hymen; the rectum was dissected from the vagina and the laterally displaced perineal bodies; the DTP appears as a whitish structure; it was traced to the ramus; a tunnel was made with dissecting scissors; the TFS applicator was inserted taking care to penetrate behind the ramus on both sides; the anchors were released; the tape was tightened and this action elevated and approximated the infero-laterally displaced perineal bodies (Fig. 1, right). The tape was infiltrated by collagen over time, strengthening PB and DTP and creating a "neo-central tendon" between the two PBs. Cure rate at 12 months [3] was in excess of 90 %. This method uses only very short thin strips of tape to approximate and reinforce PBs weakened by birth injury and age.

Compliance with ethical standards

Conflicts of interest None.

References

1. Chaudhry Z, Tamay C. Descending perineum syndrome: a review of the presentation, diagnosis, and management. *Int Urogynecol J*. 2016;27:1149–56.
2. Wagenlehner FME, Del Amo EGA, Santoro GA, Petros P. Live anatomy of the perineal body in patients with third-degree rectocele. *Colorectal Dis*. 2013;15:1416–22.
3. Wagenlehner FM, Del Amo E, Santoro G, Petros P. Perineal body repair in patients with 3rd degree rectocele. A critical analysis of the tissue fixation system. *Colorectal Dis*. 2013;15:e760–5.