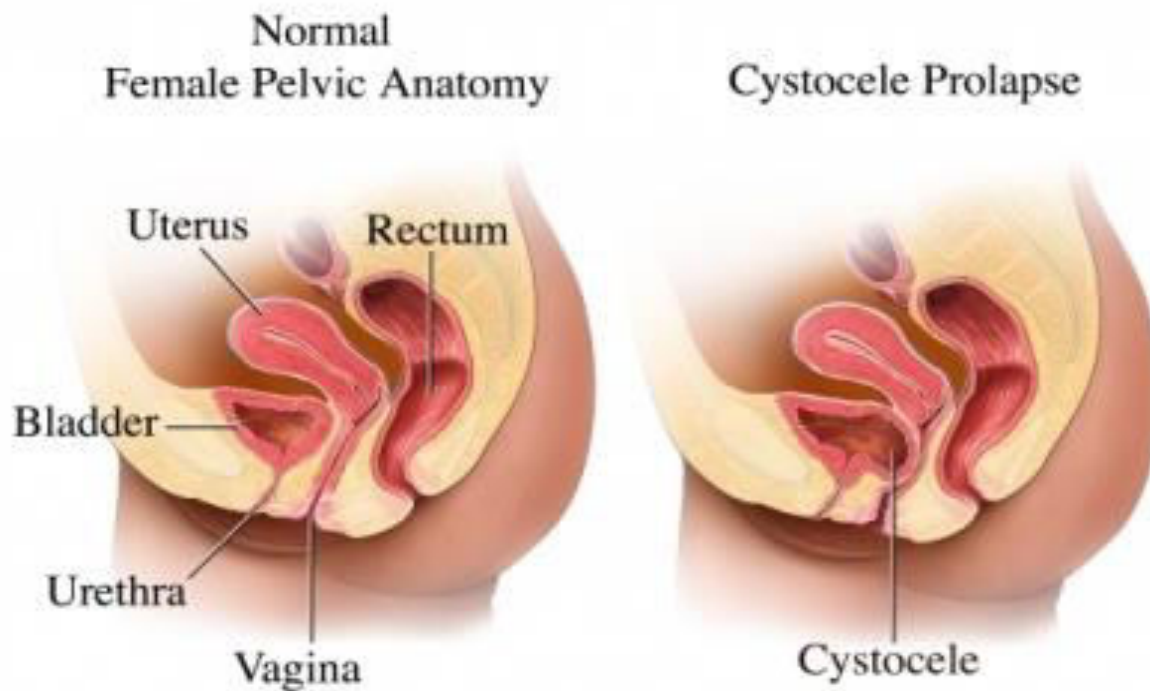


and posterior vaginal walls. The proportional roles of these factors to descending pathophysiology in distinct vaginal compartments, however, are unknown. In addition, the symptoms of prolapse in these compartments are not well understood.²Rectocele and cystocele surgery is typically performed in a hospital setting under a regional (spinal or epidural) or general anaesthetic, with patients spending one or two days. It's enticing to undertake the operation as an outpatient treatment with less bleeding and pain, no surgical support, quick discharge, and, most significantly, no compromise in postoperative results. There have been no research that we are aware of looked into the relationship between rectocele and cystocele. Cystoceles, rectoceles, and enteroceles (all other cystoceles, rectoceles, and enteroceles), uterine and vaginal cysts, and Rectoceles, enteroceles, and uterine and vaginal rectoceles are all examples of rectoceles cysts were also excluded. Cystocele and rectocele recur in the mid-vaginal plane were the most important outcome factors.⁴Female patients over the age of 30 who were having cystocele and rectocele repair surgery, treatment, or oral contraceptive pills were included in the study. Chronic diseases include diabetes, hypertension, hepatic or renal failure, and cancer.⁵ Different alternatives Depending on the topography of the access route, helical needles, curved needles, plastic sheets, and sheaths are available for situating the mesh arms to assure tissue-sparing insertion. There is currently little long-term evidence on whether the theoretical assumptions that support mesh interposition transfer to successful prolapse repair. Short-term findings, on the other hand, show that the concept is workable, but that 5.3 percent of women, despite permanent tissue replacement, develop recurrent prolapse within three months following surgery. Based on previous experience with ultrasound evaluation of the polypropylene tape in women after tension-free vaginal tape (TVT) repair, we conducted the current study to determine sonographically the postoperative size of the mesh implant, compare it to the size of the implanted mesh, and evaluate whether full support of the anterior or posterior compartment is achieved.⁶ Pelvic organ prolapse results in a slew of symptoms that get worse with time. Despite efforts to standardise clinical examinations, a variety of imaging modalities are employed. The purpose of this study was to see if dynamic pelvic magnetic resonance imaging and dynamic cystocolpoproctography could help surgeons treat patients with severe pelvic floor disorders.⁷



Patient Information: A 30 years old married female admitted in AVBR Hospital on date 28/09/2021 with chief complaints of Something coming out of vagina not feeling bladder relief immediately, frequent urinary tract infection, heaviness in vagina.

Primary Concern And Symptoms of Patient: Present case visited in AVBR Hospital in OPD base on dated 28/09/2021 with chief complaints of Something coming out of vagina not feeling bladder relief immediately, frequent urinary tract infection, heaviness in vagina.

Medical And Family And Psychosocial History: Patient suffering from Cystocele and rectocele with procedentia with cervical elongation for further management Present case belong nuclear family in her family belongs to middle

class family. She was mentally stable, she was oriented date, time and place and she maintained good relationship with family members.

Habits:

Watching TV, reading newspaper and sleeping and patient don't have any bad habit like chewing tobacco and smoking.

Relevant Past Intervention with Outcomes: Cystocele and rectocele with procedentia with cervical elongation for further management for few days before admitted in AVBRH After investigation patients diagnosis is conformed, was observed she took treatment for that and her outcomes was good.

Physical Examination clinical findings:

General Examination:

30 years female patient have unhealthy, she was conscious and oriented to date ,time and place patient body build was moderate and she was not maintain good personal hygiene, her haemoglobin was 9.7gm,pulserate is 68,blood pressure-120/90mmhg.,platlate-8lac/cumm

The patient was conscious and well oriented to date imeplace. his body built was moderate and he maintained good personal hygiene.

General Examination:state of health was unhealthy,

thin body built, but distension of necrosis the height of patient is 168 cm

weight is 50kg. her vital parameters are normal.

Timeline:

The patient was admitted for few weeks, that time patient general condition was poor, she took treatment in A.V.B.R.Hospital and she got the proper treatment. Taking proper medication and now she has been seen the improvement of condition.

Diagnostic assessment:

After physical Examination and investigation (such as CBC, Per Vaginal examination, Ultrasonography, Paps Smear,) Hemoglobin-9.7gm,cytopathology-smear shows and group of benign epithelium cells and flue clattle inflammatory cell.

Diagnosis:

After all physical examination and investigation patient diagnosis is Cystocele and rectocele with procedentia with cervical elongation.

Therapeutic Intervention:

Medical intervention: included inj.c-tax,inj.pan,inj.metro,t-bactointment,tab-iron,tab-calcium,inj.pause, She was took all treatment and outcomes was good.

Nusingperspective:IV fluid was provided to maintan the fluid and electrolyte monitored heart rate and vital sign per hourly.

Follow up and outcomes:

Follow up:

Patient advice to daily exercise, and avoid high cholesterol diet, salt diet, given healthy diet. Regular checked up , maintained the personal hygiene as well as take it properly medication by Dr order.

Outcomes:

In-spite all care patient progress good, he was advised to strictly avoid heavy work, advised to take complete bed rest

Intervention adherence and tolerability: Patients took all prescribed medication regularly, he follow diet, No, any intervention adherence. Patient tolerated treatment properly

Discussion:

The levatorani muscle and the apical descent abnormalities have been linked to Prolapse of the anterior and posterior vaginal walls. The proportional these individuals' contributions variables to the pathophysiology of descent in various compartments vaginal, however, are unknown remain uncertain. In addition, the symptoms of prolapse in these compartments are not well understood.

Because of the elegance of transobturator or transischioanal access, the ease of application using the manufacturers' needles, the variable mesh sizes that can be cut to size intraoperatively, the lack of a laparotomy, the option of permanent tissue replacement after fascial reconstruction failure, and Ulmsten's excellent experience with similar materials.⁸The simultaneous treatment of cistocele and rectocele with protesic polypropylene multifilament macropore mesh via the The tension-free transvaginal method It appears to be a secure and successful method surgery procedure. There are a variety of approaches that can be taken, and In the literature, there is currently no

significant agreement. If the rectocele is isolated or affects the low or mid rectum, a transabdominal rectopexy is more appropriate, but if the rectocele is high and/or connected to other conditions of If you have pelvic stasis, a transabdominal rectopexy is a better option appropriate.⁹

The Pelvic organ prolapse is defined as a downward descent of the pelvic organs that results in a protrusion of the vagina (POP), is a frequent disease in the United States, accounting for 300,000 surgeries each year. After cystocele, rectocele, or rectum prolapse through the POP is the second most prevalent type of POP is posterior vaginal wall (PVW). Rectocele is typically seen in multicompartiment pelvic floor disorders alongside other types of prolapse. Rectocele development mechanisms are still understood, making early detection and progression prediction difficult. Thanks to advances in imaging and computer modelling tools, a range Vaginal prolapse has been studied using a variety of finite element (FE) models, providing for a better understanding of the dynamic interactions between pelvic organs and their supporting structures systems. The majority of research has so far concentrated Little is known about anterior vaginal prolapse (or cystocele), and involvement of pelvic muscles and ligaments in rectocele's onset and progression. Based on full-scale magnetic resonance imaging, this research generated a three-dimensional (3D) computer model of the female pelvis (MRI).¹⁰ Studies on different aspects of rectal lesions were reviewed¹¹⁻¹⁶.

Conclusion:

The laparoscopic pelvic floor repair treatment combines the benefits of a with the decreased morbidity of a vaginal laparotomy operation. Although Suspension of the uterosacral ligament is the most natural anatomic restoration of abnormalities and thus the ones who are least likely to result in future deformities in Vaginal function may be hampered by the anterior or posterior vaginal wall, sacrocolpopexy was more popular in Europe. To assess the technique's utility, more research on its long-term efficiency and reliability is required. Sacrocolpopexy with mesh interposition is a method for vault prolapse that is both safe and effective. and rectocele repair. To uncover any late issues, alt is necessary to conduct long-term follow-up. Contrary to popular opinion, pelvic organ prolapse is not always chronic and progressive, as our findings show. Patients with grade 1 prolapse frequently have spontaneous regression.

References:

1. Vahabi S, Karimi A, Beiranvand S, Moradkhani M, Hassanvand K. Comparison of the effect of different dosages of celecoxib on reducing pain after cystocele and rectocele repair surgery. *The Open Anesthesia Journal*. 2020 Jun 15;14(1).
2. Berger MB, Kolenic GE, Fenner DE, Morgan DM, DeLancey JO. Structural, functional, and symptomatic differences between women with rectocele versus cystocele and normal support. *American journal of obstetrics and gynecology*. 2018 May 1;218(5):510-e1.
3. Durnea CM, Khashan AS, Kenny LC, Durnea UA, Smyth MM, O'Reilly BA. Prevalence, etiology and risk factors of pelvic organ prolapse in premenopausal primiparous women. *International urogynecology journal*. 2014 Nov;25(11):1463-70.
4. Sand PK, Koduri S, Lobel RW, Winkler HA, Tomezsko J, Culligan PJ, Goldberg R. Prospective randomized trial of polyglactin 910 mesh to prevent recurrence of cystoceles and rectoceles. *American journal of obstetrics and gynecology*. 2001 Jun 1;184(7):1357-64.
5. Vahabi S, Abaszadeh A, Yari F, Yousefi N. Postoperative pain, nausea and vomiting among pre-and postmenopausal women undergoing cystocele and rectocele repair surgery. *Korean journal of anesthesiology*. 2015 Dec;68(6):581.
6. Tunn R, Picot A, Marschke J, Gauruder-Burmester A. Sonomorphological evaluation of polypropylene mesh implants after vaginal mesh repair in women with cystocele or rectocele. *Ultrasound in Obstetrics and Gynecology: The Official Journal of the International Society of Ultrasound in Obstetrics and Gynecology*. 2007 Apr;29(4):449-52.
7. Kaufman HS, Buller JL, Thompson JR, Pannu HK, DeMeester SL, Genadry RR, Bluemke DA, Jones B, Rychcik JL, Cundiff GW. Dynamic pelvic magnetic resonance imaging and cystocolpoproctography alter surgical management of pelvic floor disorders. *Diseases of the colon & rectum*. 2001 Nov 1;44(11):1575-83.
8. Tunn R, Picot A, Marschke J, Gauruder-Burmester A. Sonomorphological evaluation of polypropylene mesh implants after vaginal mesh repair in women with cystocele or rectocele. *Ultrasound in Obstetrics and Gynecology: The Official Journal of the International Society of Ultrasound in Obstetrics and Gynecology*. 2007 Apr;29(4):449-52.
9. Aubert M, Mege D, Nho RL, Meurette G, Sielezneff I. Surgical management of the rectocele—An update. *Journal of Visceral Surgery*. 2021 Jan 22.

10. Chanda A, Meyer I, Richter HE, Lockhart ME, Moraes FR, Unnikrishnan V. Vaginal changes due to varying degrees of rectocele prolapse: A computational study. *Journal of biomechanical engineering*. 2017 Oct 1;139(10).
11. Bhojraj, Nandini, and Gaurav Sawarkar. "The Effect of Panchagavya Formulations in the Case of CA Rectum." *INTERNATIONAL JOURNAL OF AYURVEDIC MEDICINE* 11, no. 3 (September 2020): 572–74.
12. Khandare, Kiran, and Pradnya Ghormode. "Prolapsed Rectal Submucosal Hematoma in Pediatric Case." *PAN AFRICAN MEDICAL JOURNAL* 37 (October 13, 2020). <https://doi.org/10.11604/pamj.2020.37.154.26149>.
13. Sreedhar, Rashmi, Suhas Jajoo, Meenakshi Yeola, Yashwant Lamture, and Darshana Tote. "Role of Tumour Markers CEA and CA19-9 in Colorectal Cancer." *JOURNAL OF EVOLUTION OF MEDICAL AND DENTAL SCIENCES-JEMDS* 9, no. 46 (November 16, 2020): 3483–88. <https://doi.org/10.14260/jemds/2020/762>.
14. Thomas, Sophia, and Arvind Bhake. "Expression of K-Ras, P53 and Ki-67 in Precancerous and Cancerous Lesions of Colorectum." *JOURNAL OF EVOLUTION OF MEDICAL AND DENTAL SCIENCES-JEMDS* 9, no. 32 (August 10, 2020): 2261–65. <https://doi.org/10.14260/jemds/2020/490>.
15. Tote, Darshana, Rajesh Domakunti, and Sachin Tote. "Scenario of Rectal Carcinoma Cases in a Rural Setting of Central India." *JOURNAL OF EVOLUTION OF MEDICAL AND DENTAL SCIENCES-JEMDS* 9, no. 46 (November 16, 2020): 3434–38. <https://doi.org/10.14260/jemds/2020/753>.
16. Yeola, Meenakshi Eknath, and Aditya Prabhalkarrao Borgaonkar. "Passage of Gangrenous Small Bowel Per Rectum Following Superior Mesenteric Vessel Thrombosis." *JOURNAL OF CLINICAL AND DIAGNOSTIC RESEARCH* 13, no. 12 (December 2019). <https://doi.org/10.7860/JCDR/2019/42828.13381>.