Imaging in pelvic floor prolapse in elderly

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Authors: C. Martini¹, L. M. Sconfienza², D. Schettini³, A. Romani¹, N. Gandolfo⁴, G. Serafini⁴; ¹Genova/IT, ²Milan/IT, ³Genoa/IT, ⁴Pietra Ligure/IT

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Learning objectives

The purpose of this work is to illustrate US and MR imaging modalities, useful in evaluation of pelvic floor dysfunctions in elderly patients and to outline the best imaging modalities for every kind of dysfunction.
Background

EPIDEMIOLOGY

Functional pathology of the pelvic floor, causing different symptoms such as urinary incontinence, uterine or vesical prolapse, or fecal incontinency, affects a high number of women, ranging from 23.7 to 38% in the USA, with a peak of more than 60% in elderly subjects.

Age

It has been reported (Goldstein) that urinary incontinence in patients from 61 to 65 years has a 22% higher prevalence compared to women aged 50 or less. This difference increases up to 67% in women over 70 years. In The USA, a National Health and Nutrition Examination Survey (2006) found that approximately 24% of adult women have symptoms of at least one pelvic floor disorder. This proportion increased with age: 39% of women aged 60-79 years and 50% of women aged 80 years or older suffered from at least one of these disorders.

Nygaard and colleagues found that in the United States in women over the age of 80 years the prevalence of urinary incontinence is 31.7%, compared with women aged 40 to 59 with a prevalence of 17.2%.

As in the last 30 years population ageing is a matter of fact, a 45% increase of pelvic floor-related disease is foreseen. The importance of pelvic floor dysfunction is enforced to consider the changing demographics in Europe and USA. For the USA it is estimated the 85 in older segment of the population will triple from 5.4 million to 19 million by 2050 and the correlation to the lifetime risk of undergoing a single operation for incontinence by age 80 is estimated to be 11.1%. About 10-20% of these women become symptomatic over 70 years of age and about 10% of them undergoes surgery.

Comorbidities

Other reported risk factors for incontinence include comorbidities such as diabetes mellitus, obesity, parity and prior hysterectomy.

Genetics

Also quantitative and qualitative differences in collagen may contribute to pelvic floor dysfunction. Connective tissue disorders such as Marfan syndrome and Ehlers Danlos syndrome have been linked to increased prevalence of incontinence and prolapse. In
histologic studies, women with pelvic organ prolapse have been shown to have more type III collagen in pelvic floor connective tissues relative to other collagen subtypes and differences in the regeneration of elastin fibers. Other studies have shown that women with pelvic organ prolapse and stress urinary incontinence have levator ani and periurethral muscle denervation and decreased neuropeptide activity. Because these are mostly cross sectional studies, it is unclear whether these histologic differences represent causes of prolapse and incontinence or subsequent effects of the disorder.

Gene expression has been found to be different in the levator ani muscles of women with prolapse, compared with controls. In addition, a significant family history of hernias in men and women seems to be associated with symptoms of pelvic organ prolapse. However, in a twin study by Altman and colleagues, genetic effects seemed to contribute to stress incontinence and pelvic organ prolapse, but the influence of environmental factors was also substantial.

**Endocrine factors**

The role of hormone therapy on incontinence symptoms has been evaluated, too. Using data from the WHI, Hendrix and colleagues reported that menopausal hormone therapy increased the incidence of all types of urinary incontinence at 1 year among women who were continent at baseline.

**Ethnicity**

Some authors reported that there is also a difference of prevalence of prolapse and incontinence due to effect of race and ethnicity: Dooley and colleagues found that white and Mexican American women had most double prevalence rates for stress incontinence compared with blacks, but blacks had a higher rate of urge incontinence; Thom and colleagues found that the prevalence of all types of incontinence was highest in Hispanic women (36%), followed by white (30%), black (25%) and Asian American (19%) women; whereas Nygaard and colleagues found no differences among different races.

**DIAGNOSIS**

Evaluation of patients affected by pelvic floor disorders starts with clinical examination. However, clinical examination may be frequently unremarkable. Also, it may be unable to quantify clearly the entity of prolapse. Thus, an accurate pre-operative imaging evaluation is crucial.

**ANATOMY**

The pelvic floor is an anatomical structure, which plays as a support to female perineum. It is compound by muscular and fascial components: the first ones maintain the pelvic
muscular tonus, hindering gravity and the occasional increase of abdominal pressure, while the endopelvic fascia, a fibrous connective layer that connects the uterus and the vagina to the pelvic walls, helps to increase pelvic floor stability. Its anterior part is named pubo-cervical fascia and connects the anterior vaginal wall to the pubis, thus increasing the support to the vagina. Posteriorly, the endopelvic fascia is named rectovaginal fascia. The central portion of perineum is made by several support structures, such as the endopelvic fascia, the external anal sphincter, the urogenital diaphragm, and pubo-rectal muscles.

A crucial part of the pelvic floor is the levator ani muscle, made by the iliacus- and pubo-coccygeal, and the pubo-rectal muscles. The last one is a fundamental component of the anal sphincter.

The ano-rectal junction is given by the intersection between the distal part of the rectum and the anal canal, while the ano-rectal angle is given by the intersection of the posterior distal wall of the rectum and the central axis of the anal canal (this angle varies during contraction or resting of pubo-rectal muscles). The contraction of the levator ani muscle closes the uro-genital hiatus and compresses the urethra, the vagina, and the ano-rectal junction towards the pubis.

From a clinical point of view, the pelvic floor is divided into three compartments: the anterior, that includes bladder and urethra, the median, including the uterus, the cervix, and the vaginal dome, and the posterior, that contains the rectum and the anal canal.

**PATHOLOGY**

Pelvic organ prolapse is defined by the ICS as the descent of one or more of: the anterior vaginal wall, the posterior vaginal wall, and the apex of the vagina or vault. Currently, most epidemiologic studies define prolapse based on examination or patient symptom report, but not both. Two studies from the Women’s Health Initiative (WHI) including women in the United States aged 50 to 79 years reported the prevalence of any degree of prolapse (grades 1-3) based on examination to be 41.1%. The prevalence of cystocele was 24.6% to 34.3%, rectocele was 12.9% to 18.6%, and uterine prolapse was 3.8% to 14.2%. Two ancillary studies from a midwestern site for the WHI measured prolapse based on the Pelvic Organ Prolapse Quantification (POPQ) examination and used a more clinically useful definition of prolapse at or beyond the hymen. They reported the prevalence of prolapse to be 23.5% to 49.4% during a 4-year follow-up period. These studies did not consider patient symptoms.

Typically, pelvic floor dysfunctions are classified according to their anatomical location: affecting the anterior, the median, or the posterior compartment.
Overall, the degree of prolapse is regarded as mild (lower than 3 cm in respect to the pubo-coccigeal plane), moderate (between 3 and 6 cm), and severe (more than 6 cm).

Anterior pelvic floor descent under the level of pubic symphysis is defined as cystocele.

This condition can determine different degrees of urinary disturbances. Cystocele implies inferior and posterior dislocation of the uro-genital hiatus, the uterus, the vagina, and the ano-rectal junction. When cystocele occurs, the anterior vaginal wall bulges and may promote the prolapse of the vaginal mucosa.

The anatomical supports of the uterus and the vagina that stabilize the median compartment are the uterosacral ligament, the pubo-cervical fascia (that connects the lateral parts of the vagina to the pelvic walls) and the recto-vaginal fascia that connects the posterior aspect of the vagina to the perineal body, so the dysfunctions that affect the median compartment are the uterine and the vaginal prolapse. These entities are defined as a descent of the uterus or the vagina, respectively, under the pubo-coccigeal plane. When uterine prolapse occur, the cervix is translates along the vaginal canal, that is usually shortened and more horizontal.

The dysfunctions that affect the posterior compartment are the rectocele, the invagination and rectal prolapse and the enterocele.

a) rectocele: it is a bulging of the ano-rectal wall with rectal protrusion, due to laxity or rupture of the supporting systems and laxity of the endopelvic fascia.

b) invagination and rectal prolapse: these conditions imply the inversion of the rectal wall, the mucosa, and the muscular wall.

c) enterocele: it is the herniation of peritoneum and bowel loops in the recto-vaginal space through the proximal third of the vagina. It may contain ileal loops, a portion of sigma, or peritoneal fat.

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<td>0</td>
<td>no prolapse is demonstrated</td>
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<tr>
<td>1</td>
<td>the most distal portion of the prolapse is more than 1 cm above the level of the hymen</td>
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<td>the most distal portion of the prolapse is 1 cm or less proximal or distal to the hymenal plane</td>
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<td>the most distal portion of the prolapse protrudes more than 1 cm below the hymen but protrudes no farther than 2 cm less than the total vaginal length (for example, not all of the vagina has prolapsed)</td>
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<td>vaginal eversion is essentially complete</td>
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**POP-Q classification of prolapse**

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Imaging findings OR Procedure details

Several techniques are available for evaluation of the prolapse of the pelvic floor:

FLUOROSCOPY

It does not allow for evaluation of soft tissues and a concurrent evaluation of all three compartments is practically impossible.

CYSTOURETHROGRAPHY

It is employed to assess urinary incontinence, but its accuracy is low (50-60%).

DEFECOGRAPHY

It allows to evaluate the initial level of the pelvic floor and the degree of descent during evacuation.

DYNAMIC CYSTOCOLPOPORCTOGRAPHY (fig.2)

This imaging test allows for a concurrent performance of defecography and cystocolpourethrography, evaluating the rectal ampulla, the anal canal, the urethra, and the vagina at the same time during evacuation using a video recorder.

ULTRASOUND

This imaging modality has the great advantages of being low cost, readily available, easy to perform, and does not use ionizing radiations, its main limitation is the relatively narrow field of view, that does not allow for a comprehensive evaluation of all pelvic organs as a whole.

The recent introduction of three-dimensional ultrasound imaging increased visibility of prolapse and of pubo-rectal avulsion, as well as any enlargement of the uro-genital hiatus, thanks to the possibility of performing three-dimensional reformatting.

• B-mode ultrasound

Trans-labial approach allows for an accurate study of both the anterior (bladder and urethra) and medium (vagina and uterus) compartments of the pelvic floor, as well as a number of connective support structures.
The probe (high or low frequency) is applied directly on the perineum, between the labia majora, directly on the urethral meatus and the vulva. Ultrasound beam is directed upwards to visualize the hiatus of the pelvic floor and the pubo-rectal muscle, and posteriorly to visualize both internal and external sphincters. Images are acquired with the patient in gynecologic position. In functional studies of the pelvic floor, the exam must be performed with bladder replenished of urine, both at rest and during Valsalva manoeuvre. A video-loop registration can be useful to assess the urethral-vesical dynamic in relationship with others pelvic organs. Also, urethral-vesical angle and urethral funneling may be seen.

The supra-pubic scan allows for evaluating bladder morphology and wall thickness as well as residual urine after urination.

- Three-dimensional ultrasound

Volumetric evaluation allows for an acquisition of the entire volume of the posterior compartment of the pelvic floor, that can be later reformatted on different planes, according to the relevant structure to assess (fig.7). This allows for a precise evaluation of the sphincters and of the musculotendinous structures and for a representation of the anatomic structures along all possible axial-oblique and coronal plans, adapting to the anatomic plan to be evaluated. So three-dimensional ultrasound imaging increases visibility of prolapse and of pubo-rectal avulsion, as well as any enlargement of the urogenital hiatus.

Volumetric imaging of the pelvic floor can be obtained using two different techniques:

1. Endo-vaginal mechanic probes with sectorial US emission, used with a translabial approach. Dataset has a trapezoid shape;
2. Endo-rectal/endo-vaginal with circumferential US emission. Dataset has a cylindric shape.

- Endo-anal ultrasound

Endo-anal ultrasound allows for evaluating integrity of the inner and outer sphincters in patients affected by fecal incontinence. The mucosal and submucosal layers have generally a hyperechoic appearance. The inner sphincter has a uniform hypoechoic appearance and its thickness usually does not exceed 3 mm. Conversely, the outer sphincter is slightly hyperechoic with variable thickness.

Although ultrasound is a well-established imaging modality to evaluate the anterior compartment and of the anatomy of sphincters, the role of this modality in the assessment of rectocele, invagination, and prolapse is still debated. Dietz demonstrated a good correlation between ultrasound and clinical staging of prolapse of all compartments,
while other authors reported poor agreement between ultrasound and conventional proctography.

**Ultrasound evaluation of anterior compartment**

At conventional B-mode ultrasound imaging, urethra has a thin hypoechoic bandlike appearance that can be detected both on sagittal and coronal scans. The striated sphincter surrounds the hypoechoic structure and appears as a double-layer hyperechoic line when imaged on the long axis. During Valsalva manoeuvre (fig.3), in patients with urethral hypermobility or cystocele, the ultrasound beam images the urethra on the short axis. Thus, external layer could appear more hyperechoic than what can be appreciated on the long axis. Ultrasound is also extremely helpful in detecting the descent of the anterior compartment, the anterior vaginal wall, and the cystocele (fig.4) that results from them. The principal role of ultrasound in this setting is to evaluate bladder neck mobility and funneling of the internal urethral meatus. The measurement of the position of neck and urethra should be done at rest and during Valsalva manoeuvre in order to evaluate the presence of a bladder neck descent (BND).

A BND value of 20-25mm is generally considered normal, but this has not been established yet.

**Ultrasound evaluation of median compartment**

Generally, uterine prolapse is evaluated clinically. However ultrasound is able to evaluate the effects of cervical anterior displacement that results in abnormal bladder emptying in patients with retroverted uterus. In patients with antverted uterus, ultrasound may also demonstrate the presence of anterior compression on the rectal ampulla that results in obstructed evacuation (colpocele).

**Ultrasound evaluation of posterior compartment (fig.12)**

Ultrasound evaluation of posterior compartment in clinical routine is yet to come. The anal sphincters can be assessed using endoanal approach with 360° rotating probes (fig.6), with endovaginal approach, or with three-dimensional probes and subsequent image reformat on axial planes. Rotating probes have high spatial resolution and allow for evaluating also small sphincterial abnormalities. However, an extra-anal approach allows for both avoiding anatomic distortion on the anal canal and performing dynamic evaluation during sphincterial contraction. Finally, axial reformat of three-dimensional images are particularly helpful to assess the uro-genital hiatus, the elevator ani muscle, and the peri-urethral affections. The main morphological abnormality related to pelvic
floor prolapse is the direct damage or the atrophy of levator ani muscle, following direct trauma on the pudendal nerve after pregnancy and delivery. Traumatic avulsions can be assessed using three- or four-dimensional reformat of volume scans.

**Implantable devices**

Implantable sub-urethral slings (fig.8) are commonly used to treat abnormalities of the anterior compartment. They usually appear as hyperechoic structures and are easily detectable on three-dimensional reformat axial scans of the perineum at ultrasound. This imaging modality may be used to evaluate the efficiency of those devices in case of symptoms recurrence.

Meshes are increasingly used in clinical practice and failure of their positioning is a common occurrence. They can be assessed using three-dimensional ultrasound but their curvilinear course may hinder their complete visibility on a single plane. Ultrasound can be also used to detect any post-implantation complications (such as abscesses) or wrong positioning.

**MRI**

The dynamic MR of the pelvic floor can be performed by two different techniques: using open configuration MRI scanner with the patient in supine position or using closed bore configuration MRI scanner with the patient in sitting position. The second option is useful for evaluation of effects of gravity and so it allows a more physiological assessment of the anorectal dynamic during defecation. However, the identification of pathological findings can occur with both techniques without significant clinical differences. For dynamic studies of the anterior compartment it is necessary an adequate bladder repletion, while evacuation dynamic studies make it essential rectal filling with various filling materials according to the sequences to perform (generally it is used the introduction of sonographic gel in quantity between 200 and 300 ml before placing the patient in the gantry. A better highlighting of the vagina, of the fornix and of the dynamic alterations due to straining is available by filling the vagina with 50 ml of sonographic gel).

The MRI allows both a morphological and a dynamic-functional study. The morphological study is conducted through the use of Fast Spin Echo T2-weighted traditional sequences according to the three orthogonal planes of the space, allowing a very good anatomical detail of pelvic organs and muscles and so to highlight signal abnormalities or pathological asymmetries that often turn out to be the cause of altered pelvic functionality. The dynamic-functional study is generally realized through ultrafast single shot T2-weighted sequences on axial and sagittal scanning planes, with single acquisition time of 10-12 seconds, thus allowing to capture the first image in the basal state and then:
1. During contraction maneuver, in order to assess the contraction of puborectal muscle.

2. During defecatory phase with the contrast in the rectum, in order to examine the rectal alterations and the pelvic organs prolapse.

3. Post-defecatory during Valsalva maneuver, in order to identify and emphasize the presence of possible enterocele and cystocele.

The sequences performed in the individual phases can be assembled with cine-loop technique, allowing the cine-MR imaging defecography.

MR interpretative criteria (fig.13):

A) pubo-coccygeal line (PCL) drawn between the lower edge of the symphysis pubis and the last coccygeal joint. It represents the plane of the pelvic floor and it is the anatomical landmark by which the pelvic organ prolapse has to be measured

B) The H line corresponds to the plane passing through the lower margin of the symphysis pubis and the posterior wall of the rectum at the level of anorectal junction.

C) The M line is a vertical line drawn at right angles between the rear end of the H line and the PCL line. In normal conditions the H line has an extension of not more than 5 cm and the M line an extension of not more than 2 cm.

Bladder and urethra: the bladder and urethra are easily visible with MRI both in static and dynamic phase; urethral and bladder hypermobility can be demonstrated during Valsalva. An abnormal descent and rotation of the bladder floor and urethra below the pubo-coccygeal line are considered abnormal and can be defined with the term of cystocele (fig.12). However, this event is also found in subjects continents and nulliparous: the cut-off for the definition of the cystocele is set at 20 mm.

Vagina and uterus: the cervico-vaginal junction and the vaginal wall are visible in static and dynamic phase in the median sagittal plane. The uterine and vaginal prolapse is generally defined as the descent of the vaginal wall or cervico-vaginal junction below the pubo-coccygeal line; this condition can be found also in normal subjects for which the cutoff of the descent for the definition of prolapse is generally quantized in 30 mm. Only above this value functional implications with possible impediment to the rectal emptying can be found.

Puborectal function: normal puborectal contraction leads to a reduction of 11° between the contraction and the push. During pushing, the ano-rectal junction migrates superiorly
and anteriorly. During the evacuation the puborectal muscle normally relaxes, resulting in an enlargement and an increase of ano-rectal muscle. Dynamic MRI shows small changes of ano-rectal angle, due to the relaxation of the puborectal muscle during evacuation in patients with obstructed defecation. The rectocele (fig.11) is a prolapse of the anterior rectal wall whose entity is measured from the line above the anal canal. In the elderly patient rectocele less than 2 cm has to be considered normal. A prolapse over 4 cm acquires clinical significance.

The syndrome of the descending peritoneum is a complete loss of tone of the whole pelvic floor, which results in a complete descent of the pelvic floor during Valsalva or evacuation. The etiopathogenesis is various: delivery, constipation and pudendal neuropathy, associated to other diseases (eg diabetes). Defeco-MRI can quantify the descent of the anorectal junction below the PCL, furthermore the enlargement of the hiatus can determine elongation of the H and M lines with modification of caudal angle of the elevator. The syndrome can determine incontinence as well as incomplete evacuation.

This syndrome can be evaluated by anal manometry, endo-anal US realized with rotating probe, but MR-defecography can clearly demonstrate alterations related to sphincterial damage in order to plan the surgical treatment performed to solve the incontinence (if defeco-MR shows associated rectocele or enterocele, the surgical treatment to perform is different).
**Fig. 2:** Cystocolpoproctography allows to study the rectal ampulla, the anal canal, the urethra and the vagina at the same time and to evaluate abnormalities of the rectal profile and of the relationship between anterior rectal wall and posterior vaginal wall while straining and evacuating.

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Fig. 3: Evaluation of urethra and bladder neck descent during Valsalva manoeuvre.

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Fig. 4: Severe cystocele. Bladder prolapse can be appreciated at rest (a) and worsens during Valsalva manoeuvre (b). Arrows indicate bladder neck and urethra.
**Fig. 5:** Rotating probe inserted in the vagina. Cylindric volume with acoustic void in the middle (corresponding to the probe). The urethral sphincter complex is located anteriorly (full arrow). The anal sphincters are located posteriorly (empty arrow). Arrowheads indicate the levator ani complex and pubo-rectal muscles.

**Fig. 12:** (A) Axial anatomic scheme of the pelvic floor. (B) Corresponding axial reformatted trans-labial ultrasound and (C) T2-weighted magnetic resonance axial scan.
**Fig. 6**: Volumetric imaging. Reformat according the three planes of the space: (a) coronal, (b) sagittal, and (c) axial.

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Fig. 7: Volumetric imaging of a TVT. In (a) sagittal and (b) coronal section, the device can be detected on its major axis. (c) On axial reconstruction, the device can be appreciated along its major transverse axis.

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Fig. 8: Intussusception and IV degree rectal prolapse. The A (TSE - T2 axial) and B (TSE - T2 sagittal) sequences and dynamic sequences at rest (C and E) (TFFE - T2) show IV degree rectocele without prolapse of other pelvic organs. Hiatus of levator ani is pathologically widw at rest. After straining (D and F): complete descent of the pelvic floor, verticalization of the pelvic organs and worsening of the rectal prolapse, II degree cystocele, horizontalization of urethra with pathological variation of urethral-vaginal angle, prolapse of the vaginal walls, initial enterocele. Sequences in the axial straining (F) show further flaring of the levator hiatus with commitment of ileal loops in the vaginal canal.

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Fig. 13: (a) Pubo-coccygeal line. (b) H line. (c) M line.

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**Fig. 9:** Rectocele studied after filling of the rectum with about 200 cc of sonographic gel. At baseline (AB): morphological TSE T2 sequences in axial (A) and sagittal T2-TSE (B) don't not show pathological descent of the pelvic organs or pathological flaring of the levator hiatus. Lesion of the right PC muscle (arrowhead). At straining (C-D): dynamic sequences in sagittal T2 TFFE show III-IV degree rectocel. Dotted line: pubococcigeeal line.

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Fig. 10: Changes of urethral axis. At rest (AB): normal orientation of urethra in (A) and dynamic SSFSE (B) sequences. At straining (C): I degree cystocele with urethral verticalization after hysterectomy (dynamic sequence SSFSE T2) Dotted line: pubococcigeal line Solid line: urethral course

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**Fig. 11:** Enterocèle in straining in hysterectomized patient (dynamic sequences SSFSE). At rest (A and C): vagina (arrowhead); levator ani muscles (arrow. At straining (B and D): pathological flaring of levator hiatus and descent of the ileal loops into the vaginal canal.

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Fig. 14: Prolapse of anterior, medium and posterior compartment before and after surgical implantation of "mesh" (propylene net inserted by vaginal). Before treatment (A-B): at rest(A): III degree istocele, enterocoele and retocele; straining(B): high degree prolapse of the three compartments. After mesh implantation (C-D): II degree retocele Dotted line: pubo-coccigeal line.

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Conclusion

The correct diagnosis of pelvic floor dysfunctions is often very hard, both clinically and by mean of imaging and so this kind of disorders can be unrecognised and not properly treated; because of they bring many troubles to the women, such as urinary incontinence or retention, pain, dyspareunia, change in bowel habits, their diagnosis and proper treatment is of primary importance for women's psychophysical and social wellness.