Laparoscopic Modified Mesh Rectopexy

What is a laparoscopic modified mesh rectopexy?

Laparoscopic surgery is also known as 'keyhole' surgery because the operation is done through a series of four small cuts (which are 1cm or less in size) rather than a big cut in your abdomen. The operation is performed whilst you are asleep (under a general anaesthetic). Antibiotics will be given by the anaesthetist, and a urinary catheter will be placed into your bladder.

During the operation, the lowest part of the bowel (rectum) is released from its usual attachments in the pelvis, pulled up and secured again to the back of the pelvis with two sutures (stitches). A piece of synthetic mesh is placed between the back of the rectum and the back of the pelvis. This mesh is designed to be absorbed by the body in six to seven months.
A space is created between the rectum and the vagina (or prostate in males), and a second piece of this mesh is placed into that space. A special glue-type substance (Tisseel) is placed over both meshes. This technique allows both the back and the front of the rectum to be supported. The wounds are closed with dissolvable sutures, and you will be woken up before being transferred to recovery.

When is a laparoscopic rectopexy performed?

One of the most common reasons for doing this operation is for patients with 'external rectal prolapse' (bowel coming out through the anus). In some instances, the rectum may have an 'internal prolapse' or 'intussusception'. This is when the rectum prolapses internally within itself, without coming out of the anus. This may cause 'obstructed defecation syndrome' (ODS).

Patient with ODS commonly have a sensation of a blockage in the bowel which makes it difficult to pass a motion. They often have several unsuccessful visits to the toilet and may feel the need to apply pressure with a finger or hand on the perineum (the area between the anus and genitals), or into the vagina. For patients with these symptoms that have failed to be treated by a course of biofeedback and non-surgical techniques, laparoscopic rectopexy may help.

What other tests are necessary before the operation?

We will need to see you in clinic to assess your symptoms and to perform an examination. If you have an external rectal prolapse, we will examine you on either the couch or toilet, so we can fully assess the prolapse. This allows us to counsel you about the type of surgery that is available and to ensure a rectopexy is the best option.

If you have an internal prolapse it may not be obvious when we examine you. In this case we may send you for a test called an MRI defecating proctogram. This is an MRI scan that lets us see how your pelvic floor muscles and rectum act when you pass a motion. It will help us to confirm the diagnosis of internal prolapse.

Most patients undergoing this operation will also have an endoscopic (telescopic) test of the bowel. We may also perform studies on the anal sphincter to look at its structure and function (anorectal physiology and endoanal ultrasound).

What is the recovery like after surgery?

Typically, patients will wake up from the operation with a catheter (tube) in their bladder and a drip in their arm. Your anaesthetist will discuss pain control with you before the operation. Local anaesthetic is injected into your wounds whilst you are asleep to help with pain relief. For most people regular paracetamol and anti-inflammatory medication, along with mild morphine-based tablets controls any pain. We try to avoid using codeine as this can make you constipated. It is important to avoid being constipated after this operation.

On the night of your surgery, it is wise for you to sit out of bed and take a small, supervised walk if possible. You will be encouraged to eat and drink. On the first morning after surgery, your catheter will come out, and your drip will be disconnected. You will be able to eat and drink, and we encourage you to walk

around. Patients usually stay in hospital for one or two nights after surgery. For each night that you are in hospital you will receive a blood-thinning injection in your abdomen. This injection reduces your risk of getting a blood clot in the legs or lungs. You will also wear some stockings for your legs until you are back to normal activities.

We do not usually wait for you to have your bowels open after the surgery before you go home, but we like you to have passed some wind. You will be discharged with a two-week course of laxatives (usually Movicol/laxido). It is important you do not get constipated in the first few weeks after surgery as this causes pain. It is extremely important that you do not strain, especially when trying to have a bowel motion after your operation.

What do I need to do after I go home?

You will need to continue your pain relief and laxatives when you go home. Movicol can be used for up to six weeks after surgery if you find it helpful. Recovery will be different for every person but usually last around six weeks. You may be fit to drive after 2 weeks, providing you can perform an emergency stop and inform your insurance company. You can return to work after 2-4 weeks but should not do any lifting, or straining, for at least 6 weeks. You can resume normal activities as soon as you feel able to. Sexual intercourse should be avoided for at least six weeks or until you feel comfortable.

Is the operation painful?

As with all operations, you should expect some discomfort. Painkillers should be taken regularly, as this will keep the medicine at a constant level in your body and control your pain better. Always follow the instructions on the packet and never take more than the recommended dose. Your discomfort should settle after a few weeks.

DOs

- Get up and about during your admission and once you are discharged home
- Eat a healthy regular diet
- Take regular pain killers

DON'Ts

- Lift anything heavier than a full kettle for 6 weeks after your operation
- Over-strain when on the toilet
- Ignore the urge to open your bowels

- Take regular laxatives (reduce them if your stools are too soft)
- Take regular exercise (walking)
- Run/go to the gym for 6-8 weeks after your operation
- Drive for 2-3 weeks following your operation and only go back when you are pain free (check with the DVLA/your insurance policy)

Will I have a follow-up appointment?

You will have a follow up appointment with your surgeon approximately eight to twelve weeks after your operation. You may also be followed up by one of our team before this. It is important that we continue to monitor your toilet technique to try to prevent your symptoms coming back.

What are the results like from surgery?

For patients with external prolapse, the operation has a low rate of recurrence (i.e. the prolapse coming back). Our data suggests an overall risk of recurrence of around 14% at four years. Suitable patients with internal prolapse can also expect good results from surgery. For patients with ODS around 4 out of 5 patients should have an improvement in their symptoms. We cannot predict which patients will not benefit from surgery. For these patients, other additional measures can be helpful.

What are the risks and long-term effects of surgery?

All surgery has risks. Whilst this is a relatively low risk operation because no bowel is removed, there are risks that you MUST be aware of if you decide to go ahead with surgery. These risks can be divided into overall failure of the procedure and the specific risk of complications.

Failure

- Operation makes no difference to symptoms
- Prolapse recurs (about 1 in 6, or 14%)
- Constipation gets worse (very uncommon)
- Bowel leakage (incontinence) starts or gets worse (uncommon)

Operation specific complications

- Bleeding (rarely significant)

- Chronic pain
- Vaginal or rectal injury requiring repair (rare)
- Infection (1-2%)
- Urinary retention or worsening of urinary incontinence
- Sexual dysfunction (rare)
- Severe constipation (rare)
- Infection of the sacrum or inflammation of one of the spinal discs (rare)
- Conversion to open operation
- Anaesthetic complications or venous thrombosis
- Mesh related complications (erosion, fistula, pain, infection). The published literature (when looking at a permanent mesh which is stitched in the rectum or vagina) suggests a risk of around 2- 3%.

The risk of mesh infection or erosion is particularly important since this may require complex surgery to resolve and can lead to significant problems afterwards. Occasionally when someone has weak muscles around the back passage (anal sphincters) and a tendency to difficultly in controlling the bowels, or leakage, it can take several months for things to settle down following surgery. This is one reason why we recommend that many of our patients who have a rectopexy are seen for physiotherapy postoperatively. A rectopexy operation does not guarantee that a rectal prolapse can never come back. The best way to prevent this is to avoid heavy lifting and straining when opening our bowels.

Is anyone not suitable for surgery?

No. This depends on whether the patient can tolerate the operation or there are features which make the operation very difficult or even hazardous to perform.

Is there an alternative to surgery?

Yes. Prior to surgery, some patients, but especially those with obstructive defecation and internal prolapse, will be seen in our department with one of our specialist practitioners for a course of treatment. Here you will be taught a combination of correct toileting techniques, pelvic floor exercises and how to empty your rectum to avoid discomfort or incontinence. You may also try rectal irrigation (flushing the lower bowel with a water/salt solution). If these techniques help, an operation could be avoided. For any patient whose symptoms do not improve, their case will be discussed at our multidisciplinary (MDT) Pelvic Floor meeting to determine if surgery is the next suitable step. If you have an external prolapse (your bowel comes out of

your anus fully), these techniques may not be suitable for you. Your surgeon will discuss the merits and disadvantages of any different approaches. These include repairing the prolapse from 'underneath' without entering your abdomen (perineal repair), or performing a rectopexy with no mesh, using stitches to secures the rectum to the pelvis (suture rectopexy).

For further information about this, please consider reviewing the Pelvic Floor Society website: https://thepelvicfloorsociety.co.uk/patients/default.aspx

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Mae'r ddogfen hon ar gael yn Gymraeg"