What is a laparoscopic/robotic ventral rectopexy?

Laparoscopic surgery is also known as "keyhole" surgery because the operation is done through a small hole or holes made in the abdomen (tummy). This means there is no need for a much larger cut in the tummy as is the case with open surgery. Robotic surgery is a more advanced form of laparoscopic surgery, where the instruments used to perform the procedure are attached to a robot controlled by the surgeon, enabling finer movements and precision. Laparoscopic surgery is carried out under a general anaesthetic (you are put to sleep). The aim of the operation, the ventral rectopexy, is to put back the rectum (back passage) from where it has slipped in the body.

When is laparoscopic/robotic ventral rectopexy performed?

One of the most common reasons for performing the procedure is for patients with external rectal prolapse (when the bowel comes outside the body through the anus). The anus is the hole at the end of the large bowel or rectum through which food waste passes.

A newer indication for surgery is internal prolapse or "intussusception" when the rectum prolapses (slips down) internally (inside) within the rectum, but does not come out of the anus. This may cause obstructed defaecation syndrome (ODS) when there can be:

- A feeling of having a blockage in the bowel
- Difficulty passing a motion (going to the toilet to remove food waste)
- Long and often unsuccessful visits to the toilet
- A need often to put pressure with a finger or hand on the perineum (the area between the anus and the genitals or private parts) when going to the toilet
- It can sometimes cause faecal incontinence when there is some loss of control (leakage) out
- of the bowel of stools (food waste)

This type of operation may help these patients.

What other tests are necessary before the operation?

We will need to see you in clinic to assess your symptoms and to perform a physical examination.

Most patients undergoing this operation will also have an endoscopic (telescopic) test on the bowel so that the inside of the bowel can be looked at using a flexible scope.

We may also perform Anorectal Physiology and Ultrasound studies on the anal sphincter (the muscle of the anus) to look at its structure and function (how it is working).

Transit studies look at how long waste takes to pass along the bowel. A Proctogram is a series of images of the way the waste passes through the whole length of the bowel. These tests are x-ray studies that look at how well your large bowel works and to see how the pelvic organs (the organs and area around the rectum) are supported (how they hold up) when the bowel is emptied.

What does the operation involve?

The operation is performed under general anaesthetic (you are put to sleep) by laparoscopic or robotic surgery and takes between 1½ and 2½ hours. It usually involves a little cut just below the umbilicus (belly button) and 3 to 4 other small cuts on the tummy. The surgeon then operates down the front of the rectum, away from the nerves that supply the bowel and genitalia (private parts). The rectum is freed off the back wall of the vagina (female canal). For men it is freed from the bladder (which holds urine) and prostate (gland at the neck of the bladder) and a pocket made for the lower end of the mesh (mesh is a synthetic net curtain like material and comes in various different sizes), which is sewn to the front of the rectum. The top end of this piece of mesh is tacked to the sacrum or lower backbone. In some women, the vagina is also stitched to the mesh to prevent an actual or future vaginal prolapse (when the wall comes down). This operation pulls the bowel up out of the pelvis, returning it to where it should be positioned and stops it dropping down.
The position of the lower end of the mesh between rectum and vagina supports the rectovaginal septum (thin structure which separates the vagina from the rectum) and corrects any rectocele (bulge from the rectum into the vagina) and enterocoele (small bowel dropping into the pelvis between vagina and rectum).

What can I expect when I wake up from the operation?

The medical specialist who will put you to sleep before your operation will discuss pain control with you before the operation. Typically patients will wake up from the operation with a catheter (tube) in their bladder and a drip in their arm. On the first morning after surgery, your catheter will come out and your drip will usually come down. You will be able to eat and drink normally.

About how long will I need to stay in hospital?

Patients usually stay in hospital for one night after surgery.

What will I need to do when I leave hospital?

You will be discharged with a two to four week course of laxatives (medicine to help you go to the toilet). It is important you do not get constipated and strain in the first few weeks after surgery as this causes pain. The laxative can be used up to six weeks after surgery if you find it helpful.

When can I get back to normal?

You may be fit to drive after 2 weeks.
You can usually return to work after 2-4 weeks.
You should NOT do any lifting for at least 6 weeks.
You can have sex when you feel comfortable usually after four weeks.

What are the results like from surgery?

For patients with external prolapse, the operation has a very low rate of recurrence (i.e. the prolapse coming back).

Suitable patients with internal prolapse can also expect good results from surgery. For patients with Obstructed Defecation Syndrome, around 4 out of 5 will have a significant (noticeable) improvement in their symptoms. A similar percentage (number) of patients with incontinence (lack of bowel control) from internal prolapse will have improved continence (bowel control).

Unfortunately, we cannot predict those patients who will not benefit from surgery. For these patients other additional measures can be helpful if the operation does not bring improvement.

What are the risks of surgery?

This is a relatively low risk surgery because no bowel is removed. With ventral rectopexy, the nerves (which send signals round the body for it to function) are avoided and constipation only rarely gets worse. Most patients who already have constipation before the operation report that this symptom actually improves after ventral rectopexy. Some patients with obstructed defaecation and bowel leakage will not have significant improvement in their symptoms but are almost never worse after rectopexy.
There are small risks of other problems following any surgery including bleeding and infection.

Is anyone not suitable for surgery?

We have operated on elderly patients (over 90 years old) with external prolapse. Results have been quite good, though risk of developing a problem after surgery is higher in this age group. Occasionally it is not possible to perform the operation on patients who have had extensive adhesions or scar tissue following previous abdominal surgery. However a previous appendicectomy (when the appendix is removed) or hysterectomy (when all or part of the womb is removed in women) is not usually a problem.

Is laparoscopic/robotic ventral mesh rectopexy better than other prolapse operations?

As a laparoscopic/robotic (keyhole) procedure, there is no large scar on the tummy as expected in open surgery and is therefore less painful than open surgery and more cosmetic. We use mesh as this seems to produce a more long lasting result. Crucially, the operation spares the important pelvic nerves and this is why this operation does not cause constipation. Prolapse rarely comes back after laparoscopic rectopexy compared to operations from a perineal (through the anus) approach.

DOs

Do get up and about both during your hospital stay and after going home.
Do take regular laxatives (we usually recommend Movicol 3 sachets a day) to keep your motions soft.
Do gradually reduce your laxatives in the six weeks after surgery if your bowels are too loose. Patients differ enormously in their need for laxatives but it is important that for 6 weeks your bowels are on the loose side of normal.
Do drink plenty of fluids after surgery.
Do take exercise in the form of walking and swimming as soon as comfortable.
Do expect that your bowel function will be different after surgery compared to before.

DON'Ts

Don't lift anything heavier than a kettle for 6 weeks after surgery.
Don't get constipated or strain when on the toilet.

Don't ignore the urge to go to the toilet.
Don't be concerned if you do not open your bowels for 4-5 days after surgery; this is quite normal.
Don't do running or gym work for six weeks.
Don't have sexual intercourse until comfortable, usually after four weeks.
Don't drive for two weeks after surgery
Don't suffer discomfort unnecessarily. You should take Paracetamol regularly if needed; this will not cause constipation.