Laparoscopic Ventral Rectopexy

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This is a keyhole operation performed for patients with external rectal prolapse, it is also used for patients with symptoms of obstructive defeacation who have an internal prolapse, also known as rectal intussusception.

Patients with internal external prolapse with a rectocele, enterocele or sigmoidocele may also benefit from the procedure.

What does the operation involve?

In most cases ventral mesh rectopexy is performed as a laparoscopic (keyhole) procedure.

During the operation the lowest part of the bowel (rectum) mobilised on one side. A mesh made of polypropylene is fastened to the front of the rectum using stitches. The mesh is then fixed using special tacks to the bone at the back of the pelvis known as the sacrum. This has the effect of pulling up the bowel and preventing it prolapsing downwards.

The operation usually involves only 3 or 4 small incisions, no larger than 1cm.

Occasionally the operation cannot be done as a key-hole procedure and an open operation is required.

What are the risks?

There are small risks associated with any abdominal operation. Pre-operative assessment of heart, lung and any coexisting medical conditions is made before admission. During the hospital admission patients wear stockings and are given a regular tiny injection to prevent thrombosis (blood clots).

Bleeding if very rare in this type of surgery and wound infections are uncommon.

Sometimes during the operation, the surgeon discovers that it is not possible to carry out the procedure using a wholly key-hole approach. In this situation a cut is made, and the operation is done as an open procedure. This is known as conversion.

In some cases, the operation, whilst correcting the prolapse, may not improve bowel symptoms. The surgeon will discuss this with you.

Rarely the mesh used to pull up the bowel can erode into it. If this happens the mesh or part of the mesh may need removing.

Some patients may experience chronic pelvic pain after mesh rectopexy.

The potential risks of mesh use in pelvic surgery have been extensively investigated and reported. Whilst serious complications of pain and erosion are not common, ventral mesh rectopexy is currently not commonly performed. Mesh rectopexy may be recommended when other treatments are not helping. When mesh rectopexy is recommended it will be after careful discussion with patients and other clinicians in the multidisciplinary team.

What happens after the operation?

After the operation a drip is normally in place for 24 hours

Patients are allowed to eat and drink as soon as they feel able after the operation (usually the same day).

A catheter (tube passed into the bladder) is required during the procedure and is usually removed the day after surgery.

Hospital stay is usually 2-5 days. After the operation patients are given as regular stool softener to take for 4-6 weeks and are advised to avoid straining.

Patients are encouraged to keep mobile after the procedure. They should avoid heavy lifting or increased physical activities for about 6 weeks. Patients can normally resume driving after about 2 weeks but this may vary particularly if the operation is done as an open procedure.