

# Laparoscopic Ventral Rectopexy

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## What is a laparoscopic ventral rectopexy?

The term “rectopexy” refers to an operation in which the rectum is suspended back into its normal anatomical position.

## When is laparoscopic ventral rectopexy performed?

One of the most common reasons for performing the procedure is for patients with **external rectal prolapse** (bowel coming out through the anus). A newer indication for surgery is internal prolapse or “intussusception” when the rectum prolapses internally within the rectum, without coming out of the anus. This may cause **obstructed defaecation syndrome** (ODS). These patients commonly have a sensation of a blockage of the bowel, difficulty in passing a motion, prolonged (often unsuccessful) visits to the toilet and a frequent need to apply pressure with a finger or hand on the perineum, in the vagina or the anus to empty the bowels. Internal rectal prolapse sometimes causes **faecal incontinence** and laparoscopic ventral rectopexy 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 an examination. Most patients undergoing this operation will have an endoscopic (telescope) test on the bowel. We will also perform studies on the anal sphincter to look at its structure and function (anorectal physiology and ultrasound) and transit studies and a proctogram. These tests are X-ray studies that look at how well your large bowel works and how well supported your pelvic organs are during the process of emptying your bowels.

## What does the operation involve?

The operation is performed under general anaesthetic by keyhole surgery and takes about one and a half hours. It usually involves a little cut just below the umbilicus (belly button) and two other small cuts on the right side of the tummy. The surgeon then operates down the front of the rectum, away from the nerves supplying the bowel and genitalia (figure 1). The rectum is freed off the back wall of the vagina (the bladder and prostate in men) and a pocket made for the lower end of the mesh which is stitched to the front of the rectum. The top end of this piece of mesh is tacked to the sacrum or lower backbone (figure 2). In women, the vagina is stitched to the mesh to prevent an actual or future vaginal prolapse. This operation pulls the bowel up out of the pelvis, restoring it to its normal anatomical position and prevents it re-telescoping down (figure 3).

The position of the lower end of the mesh between rectum and vagina supports the rectovaginal septum (figure 4) and corrects any rectocele (bulge from the rectum into the vagina) and enterocele (small bowel dropping into the pelvis between vagina and rectum).

## 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. 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. Patients usually stay in hospital for one or two nights after surgery. You will be discharged on a weaning course of laxatives (usually movicol) and you should take these for six weeks. It is important you

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do not get constipated and strain in the first few weeks after surgery as this causes pain. You may be fit to drive after a week, return to work after 2-4 weeks but should not do any lifting for at least 6 weeks.

## **What are the results like from surgery?**

For patients with external prolapse, the operation has a very low rate of recurrence (ie the prolapse coming back). In our experience of around 200 operations for external prolapse, fewer than 2% recur.

Suitable patients with internal prolapse can also expect good results from surgery. For patients with ODS (see above), around 4 out of 5 will have a significant improvement in their symptoms. A similar percentage of patients with incontinence from internal prolapse will have improved continence.

We cannot predict those patients who will not benefit from surgery. For these patients other additional measures can be helpful.

## **What are the risks of surgery?**

This is relatively low risk surgery because no bowel is removed. Older versions of rectopexy involved removing segments of bowels and making joins that could leak, causing peritonitis. Bowel was removed to offset the worsening of constipation that rectopexy would often cause as a consequence of nerve damage. With ventral rectopexy, the nerves are avoided and constipation only very rarely gets worse. Most patients with pre-existing constipation report that this actually improves after ventral rectopexy.

Some patients with obstructed defaecation and incontinence will not have significant improvement in their symptoms but are almost never worse after rectopexy. There are small risks of other problems including bleeding and infection.

## **Is anyone not suitable for surgery?**

We have operated on elderly patients (over 85 years old) with external prolapse. Results have been favourable, though risk of morbidity is around 10% in this age group. Occasionally, it is impossible to perform the operation on patients who have had extensive previous abdominal surgery because of adhesions (though a previous appendicectomy or hysterectomy is not usually a problem).

## **Is laparoscopic ventral mesh rectopexy better than other prolapse operations?**

As a laparoscopic (key hole) procedure, this operation is more cosmetic and less painful than open surgery (cut down the middle of the tummy). We use mesh as this seems to produce a more long lasting result. Crucially, we dissect out the rectum down its front ("ventral" or "anterior") side only, thus sparing the important pelvic nerves and this is why this operation does not cause constipation. Prolapse rarely comes back after laparoscopic rectopexy (less than 2%) compared to operations from a perineal (through the anus) approach (over 20%).

We collect, publish and present very detailed data on our surgical results and would be happy to discuss this in more detail with you when you come to clinic.

## **How do I get seen in the Oxford Pelvic Floor Centre?**

All we need is a referral from your GP or hospital specialist to the address/fax numbers below.

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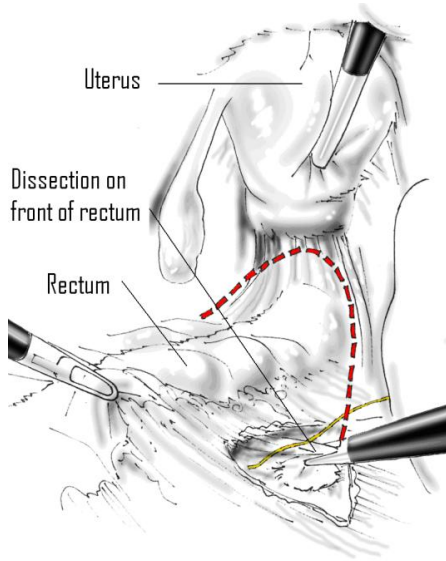


Figure 1: Start of a laparoscopic ventral mesh rectopexy. The surgeon retracts the uterus forwards and starts dissection on the front (ventral) part of the rectum, following the red line on this diagram and into the rectovaginal septum (the space between rectum and vagina).

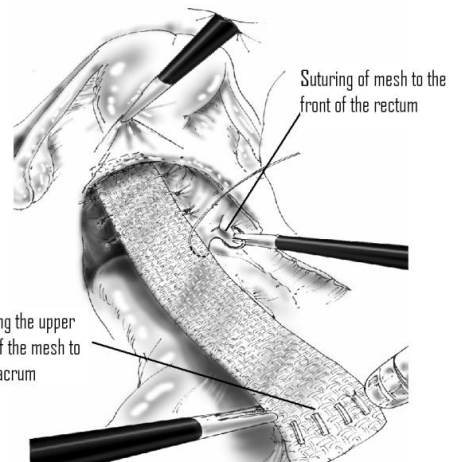


Figure 2: The surgeon creates a pocket between the lower rectum and vagina and the mesh is sutured on to the front of the rectum, whilst the other end is fixed to the sacrum (backbone).

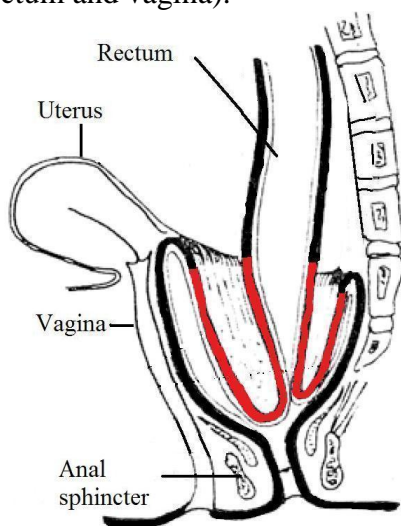


Figure 3: Diagram showing the rectum telescoping down into itself. In this diagram, this is an internal prolapse though in time, this may progress to an external prolapse.

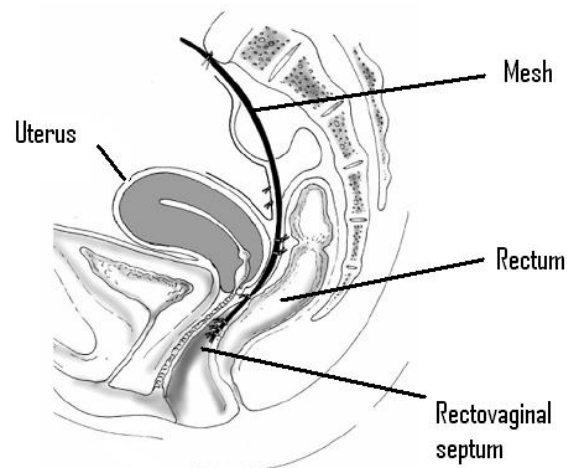


Figure 4: Cross sectional view with the mesh supporting the rectovaginal septum. In this manner a rectocele (bulge into the vagina) and enterocele (small bowel coming into the pelvis) are corrected.

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<b>DO s</b>	<b>DON'T s</b>
<p><b>Do</b> get up and about both during your hospital stay and after going home.</p> <p><b>Do</b> take regular laxatives (we usually recommend movicol one sachet three times a day) to keep your motions soft.</p> <p><b>Do</b> 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 six weeks, your bowels are on the loose side of normal.</p> <p><b>Do</b> take exercise in the form of walking and swimming as soon as comfortable.</p> <p><b>Do</b> drink plenty of fluids after surgery.</p> <p><b>Do</b> expect that your bowel function will be different after surgery compared to before.</p>	<p><b>Don't</b> lift anything heavier than a kettle for six weeks after surgery.</p> <p><b>Don't</b> get constipated or strain when on the toilet.</p> <p><b>Don't</b> ignore the urge to go to the toilet.</p> <p><b>Don't</b> be concerned if you do not open your bowel for 4-5 days after surgery. This is quite normal.</p> <p><b>Don't</b> do running or gym work for six weeks after the surgery.</p> <p><b>Don't</b> have sexual intercourse for four weeks after the surgery.</p> <p><b>Don't</b> drive for two weeks after surgery.</p> <p><b>Don't</b> suffer discomfort unnecessarily. You should take paracetamol regularly if needed. This will not cause constipation.</p>

**There is little “wrong” that you can do after a laparoscopic rectopexy. The most important things to avoid are constipation and heavy lifting.**

Figure 5: Things to do and things to avoid after a laparoscopic ventral rectopexy.

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