Patient Information Leaflet

Laparoscopic Ventral Rectopexy

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What is a laparoscopic ventral rectopexy?
The term “rectopexy” refers to an operation in which the rectum (the part of the bowel that is nearest the anus) is put back into its normal position in the body.

When is laparoscopic ventral rectopexy performed?
One of the most common reasons for carrying out this procedure is for patients with external rectal prolapse (bowel coming out through the anus). Another reason for surgery is internal prolapse or “intussusception” when the rectum slides in on itself, without coming out of the anus. This may cause obstructive defaecation syndrome (ODS), a sensation of a blockage in the bowel, difficulty in passing a motion (having a poo) and prolonged, often unsuccessful visits to the toilet. It can also mean you need to apply pressure with a finger or hand on the perineum (skin between the vagina/testicles and the anus), in the vagina or the anus to empty your bowels. Internal rectal prolapse sometimes also causes faecal incontinence (when you are unable to hold a bowel movement in).

What other tests will I need before the operation?
We will need to see you in clinic to assess your symptoms and to perform an examination. Most patients who have this operation will have an endoscopic (telescope) test on the bowel. We will also look at how well the back passage muscles (anal sphincter muscle) work using manometry (to assess the strength of the sphincter muscles) and an ultrasound scan to look at the sphincter muscles. We may also assess the motility of the gut with an X-ray (slow transit study). This is because many patients who have obstructive defecation syndrome (ODS) have a slow colon which if not managed could affect the results of the operation. All of these tests are necessary to check that laparoscopic ventral rectopexy is right for you.
**What does the operation involve?**
The operation is laparoscopic (keyhole surgery) and it involves a little cut just below the umbilicus (belly button) and two other small cuts on the right side of the tummy. There may be another small cut on the left side of the tummy. It is performed under general anaesthetist (whilst you are asleep) and usually takes about two-three hours. This operation pulls the bowel up out of the pelvis and a mesh is put in place to hold the bowel in its normal place in the abdomen. The mesh will also prevent it from prolapsing back down into the pelvis (intussusception).

The mesh we use is biological tissue which allows your own tissue to grow onto the mesh. It has a much better safety profile compared to synthetic or man-made mesh.

**What is the recovery like after surgery?**
After the operation you will normally have a urinary catheter in place (a tube into your bladder) and a drip in your arm. You will be allowed to eat and drink as soon as you want to after the operation, and your drip will be removed once you are drinking enough. Your anaesthetist will talk about pain control with you before the operation but usually painkilling tablets and liquids will be enough.

Usually, early on the day after your operation your catheter will be removed and you can walk to the toilet to pass urine. You should be able to go home the day after the operation. It is important to avoid constipation and straining in the first few weeks after surgery. We will give you laxatives to take (usually Laxido) until you are reviewed in the clinic.

You should be fit to drive after a week and return to work after 2-4 weeks. You should not lift anything heavier than a full kettle for at least 6 weeks as this can cause excess
strain on the pelvic floor muscles and can delay healing; this includes supermarket shopping, housework, lifting children and sports.

**What are the results like from surgery?**
If the operation is performed due to an internal prolapse, obstructed defaecation syndrome or faecal incontinence, about 4 out of 5 patients report a significant improvement in their symptoms.

**Failure**
- Operation makes no difference to symptoms (about 1 in 5 or 20%).
- Prolapse recurs (about 1 in 5 or 20%).
- Constipation gets worse not better (very uncommon).
- Bowel leakage (incontinence) gets worse not better. Occasionally new-onset incontinence can occur (uncommon).

**Specific complications**
- Bleeding (rarely significant).
- Vaginal or rectal injury requiring repair (rare). A vaginal injury can be safely repaired but an injury to the rectum may result in an infection requiring a stoma.
- Infection (1-2%).
- Urinary retention (<10%) or worsening of urinary incontinence.
- Mesh erosion (where the mesh wears away surrounding tissue) (2-3%).
- Sexual dysfunction in men (rare).
- Severe constipation (rare).
- Pain during sexual intercourse (uncommon and usually gets better with time).
- Infection of the sacrum (inflammation of one of the discs of the spine) (rare).
- A false passage between the rectum and the vagina
(fistula). The false passage may allow bowel gas and content to pass through the front passage. This can be corrected with a further operation (rare).

- Injury to other abdominal structures (rare).
- Pelvic pain and / or back pain.
- Blood clots in the legs / lungs (thrombosis) (rare).

This is relatively low risk surgery because no bowel is removed. With ventral rectopexy, the nerves are avoided and constipation only very rarely gets worse. Most patients with pre-existing constipation report that this improves after ventral rectopexy. Some patients with obstructed defaecation and incontinence will not have a significant improvement in their symptoms, but are rarely worse after rectopexy. There are small risks of other problems including bleeding, infection, a hernia or bulge at one of the wounds or a problem with the mesh entering or piercing the bowel or vagina. This can happen months or even years after surgery. A problem with the mesh can occur in about 2-3% (Pelvic Floor Society) and if it does, further surgery may be needed to correct it. You will have the opportunity to discuss all the risks and benefits of the operation with your surgeon before signing the consent form.

**Is anyone not suitable for surgery?**

We have operated on elderly patients (over 85 years old) with external prolapse with good results, though these patients are at increased risk due to their age. Occasionally it is impossible to perform this operation on patients who have had extensive previous abdominal surgery because of adhesions (scar tissue in the abdomen), though a previous appendicectomy or hysterectomy is not normally a problem. We tend not to offer the operation to patients with back pain because of the risk of making the back pain worse.
Is laparoscopic ventral mesh rectopexy better than other prolapse operations?
A laparoscopic (keyhole) procedure leaves less scarring and is less painful than open surgery (a cut down the middle of the tummy). We use mesh as this gives a longer lasting result than not using it. We carefully avoid damaging the important pelvic nerves which can cause constipation. Prolapse rarely comes back after laparoscopic surgery (2%) as opposed to operations through the perineum (10-30%).

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 enterocoele (small bowel coming into the pelvis) are corrected.
DO’s

Do get up and about both during your hospital stay and after going home. Do take regular laxatives (we usually recommend movicol one sachet three times a day) to keep your motions soft. Do gradually reduce your laxatives in the eight weeks after surgery, if your bowels are too loose, but remain taking a small dose. Patients differ enormously in their need for laxatives but it is important that for eight weeks, your bowels are on the loose side of normal. Do take exercise in the form of walking and swimming as soon as comfortable.

DON’Ts

Do drink plenty of fluids after surgery. Do expect that your bowel function will be different after surgery compared to before. Don’t lift anything heavier that a kettle for six 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 bowel for 4-5 days after surgery. This is quite normal. Don’t do running or gym work for six weeks after the surgery. Don’t have sexual intercourse for four weeks after the surgery. 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.

Acknowledgement

Oxford Pelvic Floor Centre.

Pelvic Floor Society: http://thepelvicfloorsociety.co.uk
What do I need to know about having a mesh?

What is a mesh?
MESH is a foreign material implanted or inserted into the human body to support, reinforce or replace tissue that has become weak or deficient. The MESH is used in certain circumstances to try to replace or strengthen tissues that have lost their support. MESH was originally used to repair hernias and has been found to be relatively safe in this use. There are concerns that the MESH implant can become infected as it is a foreign body. Surgeons are therefore careful in selecting patients for MESH implant and surgeons use MESH when it is relatively safe and necessary.

A mesh is often used in prolapse surgery. A prolapse is a protrusion of the rectum (lower bowel) from outside the anus and it can come completely out after having your bowels open. It can be caused by sagging of the natural supporting tissues which usually hold the rectum in place. The mesh is used to try to replace or strengthen these supporting tissues. There are lots of different meshes available. Some are absorbed by the body and form lots of scar tissue which supports the lower bowel. Others do not absorb and therefore stay in place forever. Other meshes are made from a ‘biological’ tissue, usually derived from pig skin, which are supposed to become part of the body’s normal tissue over time.
What is the advantage of using a mesh?
During operations for prolapse, the surgeon tries to repair or strengthen the weakened supporting tissues. However, it has been known for a long time that these repairs can fail. This can mean that the prolapse comes back. In order to reduce the risk of surgery failing, mesh materials have been developed with the aim of strengthening the repair. Permanent mesh provides lifelong strength.

The first meshes used were similar to the strong meshes used by surgeons to treat a hernia (rupture) in the tummy wall. However, the vagina is very different to the tummy wall and the meshes have changed over the years as we have learnt more about how they behave once they have been inserted.

What are the disadvantages of a permanent mesh?
Unfortunately, there are disadvantages of inserting any artificial material into the body. Rarely, the material can become infected or recognised by the body as ‘foreign’ and be rejected. Scar tissue can form around the mesh making the rectum and vagina stiffer and could cause pain. This pain could be felt during sexual intercourse. This problem is seen more often when a mesh has been used for a prolapse of the vagina, rather than the bowel.

Over time, the mesh can wear through the tissues so that it pokes through the wall of the bowel, and it is possible to come through the wall of the vagina. This is called erosion and can occur many years after the mesh has been put in. This is more common with surgery for a prolapse of the vagina rather than a bowel prolapse. Not all meshes are the same and some seem to have much lower risks of problems than others. However, erosion often needs further surgery to remove parts or all of the mesh. Removing mesh from bowel can be complicated surgery. In contrast, prolapse is not dangerous or harmful condition. The risk of having complications from the mesh needs to be weighed carefully against the bother you are getting from your condition.
What are the disadvantages of an absorbable mesh?
Absorbable meshes are gradually absorbed by the body. The speed at which this happens is different for everyone. For some women, the mesh can absorb and disappear very quickly before the body has had time to heal fully from the surgery. This may make it more likely that the prolapse will come back. For other women, the mesh is absorbed very slowly and can be still there many years after it was put in.

Absorbable meshes can become infected or rejected in the same way as permanent meshes. They have less risk of wearing though tissues over time and are very unlikely to wear through the bowel wall or vagina in the long term. However, they seem to have a much lower chance of preventing the prolapse coming back than permanent meshes. Therefore the risk of the prolapse coming back over time is higher with an absorbable mesh.

In the operation the ventral mesh rectopexy, (also called an LVR) we currently don’t know which type of mesh is the best in relation to avoiding mesh erosion or reducing the risk of the prolapse coming back in the future. The advantages and disadvantages of using a mesh in your operation will be discussed with you by a specialist surgeon and they will select an appropriate mesh for your prolapse to minimise the risks or complications.

If I would like a prolapse repair that uses mesh, what can be done to reduce the risk of a mesh complication?
Most women in the UK having an operation for prolapse will not need mesh. Mesh can be very helpful in operations for rectal prolapse (Laparoscopic mesh rectopexy). At the start of these operations, antibiotics are given to reduce the risk of the mesh becoming infected. Smokers are at much higher risk of mesh erosion than non-smokers. Stopping smoking may, therefore reduce the risk.
What do other doctors/organisations think about using mesh?
Surgeons have had concerns for many years about the potential for meshes to cause complications in some women. Several studies have been performed to try to find out exactly what the advantages and disadvantages of these operations are. So far, the results have given different, sometimes opposite, results. Some very large studies are being performed in the UK at the moment and they will provide more information over the next few years.

The FDA (the US Food and Drug Administration, who regulate mesh in the USA) have also been concerned about mesh complications. They have published advice for both doctors and patients in the USA about using mesh. They are more concerned about vaginal mesh repairs for prolapse rather than mesh used for rectal prolapse repairs. The National Institute for Health and Clinical Excellence (NICE) have also published advice for doctors about using mesh in the UK.

How will I know if I have developed a problem with my mesh?
Although problems can occur, MOST women will never have a problem with their mesh. If a problem does occur, the symptoms can be vague and ‘non-specific’. This means that they could be caused by other things and not your mesh. However, if you are worried about your symptoms you should be seen by your specialist even if you develop problems years after your operation. Problems with your mesh can be difficult to spot and you should be seen at a specialist pelvic floor centre can be helpful.

Mesh problems can give symptoms such as:
- Pain in the vagina or bladder (front passage)
- Pain around your rectum (back passage)
- Pain during sex for you or your partner.
- Discharge or bleeding from the vagina or rectum (bowel)
• Frequent urinary tract infections.
• Worsening problems with having to rush to pass water or going to pass water very frequently.

If you have concerns, you should discuss them with your surgeon.

If you do experience a mesh complication, you can expect us to:
1. Explain the diagnosis and treatment necessary to you in a way that you can understand.
2. Report the mesh complication to the relevant authority (in the UK this is the Medicines and Healthcare products Regulatory Agency (MHRA) in a way that protects your medical confidentiality.

We are continuing to monitor patients who have a mesh as part of a prolapse operation via The Pelvic Floor Society.

I have had a mesh inserted in the past, should I be worried?
As it says above, most women will never have a problem with their mesh. If you have no symptoms which might suggest a problem, there is no need to worry. If symptoms start and you are worried, speak to your GP and ask to see a specialist if necessary. Stopping smoking might help to reduce the risk of a problem occurring in the future.

Checklist of questions to ask your doctor before having a mesh inserted
You should let your doctor know if you have had a reaction in the past to mesh materials such as polypropylene. You might find it helpful to ask your doctor the following questions before having an operation which involves mesh:
• What are the pros and cons of using mesh in my particular case?
• Could the operation be done without mesh?
• What is your experience of using this particular mesh?
What experience have your other patients had with this product?

- What is your experience of dealing with complications from this product?
- What should I expect to feel after my operation and for how long?
- Are there any specific side effects that I should let you know about after the surgery?
- What happens if the mesh doesn’t help my problem?
- If I have a complication, can the mesh be removed and what would the consequences be?
- Is there a patient information leaflet that comes with the product? Can I have a copy?

Other sources of information

The Pelvic Floor Society website has a statement regarding the use of mesh in rectal prolapse surgery, including other patient information leaflets on procedures for rectal prolapse. The Royal College of Obstetricians and Gynaecologists has a statement about mesh use, which includes some useful links to other websites, here: www.rcog.org.uk/news/rcog-statement-report-commissioned-mhra-vaginal-tape-and-mesh-implants

The FDA advice regarding mesh can be found here: www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm142636.htm#popsui

There is information about medical devices, such as mesh, available from the MHRA. Their website can be found at: www.mhra.gov.uk

The NICE guidelines about mesh procedures for pelvic organ prolapse can be found on their website: www.nice.org.uk