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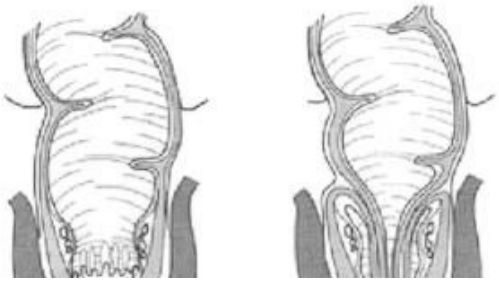
Abdominal Rectopexy Operation for Rectal Prola



What is a rectal prolapse?

A rectal prolapse occurs when the normal supports (rectum) become weakened, allowing the muscles down through the back passage (anus) to the outsi only happens when you open your bowels, and goes back on its own. In more severe cases, the rectum may need to be pushed back after opening the bowels, or may even stay outside all the time.

While not a dangerous or life threatening condition this can be very uncomfortable, a considerable nuisance, and may cause loss of bowel control. There may also be a mucus or bloodstained discharge.

How will the operation help me?

A rectopexy operation is performed to restore the anatomy, improving function with the hope of preventing further prolapse. This operation can be performed either laparoscopically (keyhole) or through an abdominal incision.

If done using a keyhole approach it usually involves a little cut just below the belly button and three or four small cuts on the tummy. The keyhole approach may include the use of robot assisted technology. On occasion the operation may be changed to an open approach using an abdominal incision. The surgeon will discuss which approach will be used.

Sometimes a mesh (a sterile sheet of netting) is used to hold the bowel in position. The mesh is then fixed with special tacks or stitches to the bone at the back of the pelvis (the sacrum). Your surgeon will discuss with you what is recommended in your particular case. There are two types of mesh; Non-natural material (Synthetic) and biological (derived from animal tissues). Your surgeon will discuss this with you.

What are the risks/complications of surgery?

General risks with surgery:

- No improvement or worsening of existing symptoms
- Infection (Urinary tract, wound, chest) <5%
- Blood clots in your legs or lungs
- Bleeding during or after surgery
- Urinary retention

Additional risks with Rectopexy:

- Mesh-related complications (<1%): infection, erosion, technical failure.

- When a mesh-related infection or erosion occurs, surgical removal of the mesh may be required.
- Fistula (development of an opening between the rectum and the vagina or other organs)
- Injury to your bowel/rectum
- Ureteric injury (damage to the tubes that carry urine from the kidneys to the bladder).
- Bladder injury
- Faecal urgency
- Making your faecal incontinence worse
- In men there is a very small risk that the operation will damage (sometimes permanently) their ability to sustain an erection or achieve ejaculation. You should discuss this with your surgeon before proceeding.
- In Women dyspareunia (painful sexual intercourse) may happen.
- Recurrence: the recurrence rate is between 10-20%.

These risks and complications will be explained to you when the surgeon asks you to sign the consent form for the operation.

Are there any alternatives?

For a large (full thickness) rectal prolapse, surgery remains the main treatment with the support from physiotherapists. Operations directly on the prolapse from below (Delorme's or Altemeier's) procedure are performed and this will be discussed as an alternative.

Coming into hospital?

You will attend the pre-admission assessment clinic prior to admission to ensure that you are fit for surgery, allowing time for the necessary pre-operative tests, which may include blood tests, cardiogram (ECG) and a chest x-ray.

You will be admitted on the day of the operation. It may be necessary to clear the bowel before the operation, so you will be given a phosphate enema on admission to empty the rectum before your operation or your consultant may request you have a laxative medicine called 'Picolax' to drink the day before your operation, which will cause frequent bowel actions, to clear your bowels. When you are being given a laxative medicine, you will be required to drink plenty of the allowed fluids, as the laxative effect may dehydrate your body if you do not maintain an adequate fluid intake.

The surgeon performing the operation will come and see you and you will see the anaesthetist. If you have any questions about your operation please ask the doctors.

The operation is usually carried out under general anaesthetic. We usually want you to stay on hospital until you are reasonably comfortable.

What should I expect after my operation?

Every effort will be made to reduce any pain or discomfort you may experience after your operation. You will be given painkilling medication either through a drip in your arm (patient controlled analgesia) or by epidural, where a thin plastic tube inserted into your back. When you are allowed to drink, you will be encouraged to take painkilling medication by mouth. Once you are tolerating oral medications the epidural or patient controlled analgesia will be discontinued. Sometimes after surgery using a keyhole approach you may experience pain in the shoulder which usually settles with mobilisation.

You will have an intravenous drip in your arm and a catheter to drain your bladder. When you are awake you will be able to drink as you wish, and when you are drinking well the drip in your arm can come out. The doctors may decide that it is necessary for you remain on fluids only for several days before you start eating, this will be explained to you by the doctors and/or nursing staff. It is not uncommon to have some difficulty or discomfort when passing urine for the first time after the catheter comes out.

Once you have passed wind after a day or two you will be given laxatives to soften your stools and stimulate a bowel action. You may not feel the need to open your bowels for a day or two. When you do, you may experience some discomfort and a little bleeding, this is to be expected.

If the muscles around the back passage (anal sphincter) are weak you may find it difficult to control your bowels, or leakage, this does not always improve after the operation. Sometimes some exercises to strengthen up the sphincter will help and you may be referred to see a Physiotherapist.

What do I need to do after I go home?

The time taken to get back to normal activities varies a lot for different people. Do as much as you feel comfortable doing. Most people need about 1-2 weeks off work, but this will depend a little on what you do, and it is important that you pay attention to your body, and only do as much as feel able to do. If you require a ‘Sick Note’ for work please ask a member of staff before discharge.

You can resume sexual activity as soon as this feels comfortable.

You must not start driving unless you feel ready to do so. It is important to ensure you are comfortable and your concentration is not impaired.
Most people do not start to drive for at least 2 weeks.

A rectopexy operation does not guarantee that a rectal prolapse can never come back. The best way of helping this is to avoid heavy lifting and straining to open your bowels. Some people find that a rectopexy makes emptying the bowels more difficult and in some cases your doctor may advise use of laxatives to ensure that you do not strain.

If you have a tendency to constipation, try to increase the amount of fibre in your diet.

Fibre forms the structure of cereals, fruit and vegetables. It is not completely digested and absorbed by the body, so it provides bulk to the stools. This helps the movement of waste through the intestines, resulting in soft stools, which are easy to pass.

You should increase the amount of fibre in your diet gradually - sudden increase can cause abdominal discomfort and wind. If fibre in your diet is not enough to keep your stool soft then consider taking a fibre supplement, such as fybogel.

It is important to ensure that you drink plenty of fluid, try to take at least 6-8 cups of fluid a day. The fluid can be any type, including water, tea, coffee, fruit juice and soup.

If you become pregnant you will need to take special care not to become constipated.

Points of contact:

If you have any queries prior to the procedure outlined and the implications for your relatives/carers, please contact the Surgical Pre-Admission Assessment Clinic on 01603 287819.

If you have any queries following the surgery please contact the ward from which you were discharged via the main hospital switchboard on 01603 286286.

For further information and support:

NHS Choices www.nhs.uk

For Help Giving Up Smoking: SMOKEFREE NORFOLK 0800 0854 113

This sheet describes a medical condition or surgical procedure.

It has been given to you because it relates to your condition; it may help you understand it better. It does not necessarily describe your problem exactly. If you have any questions please ask your doctor.

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