

James Aitken

MB, BS; LRCP, MRCS; MS; FRCS (Edin); FCS(SA); FRACS

General and Colorectal Surgery

Unit 4,
77 Grand Boulevard,
Joondalup, 6027

Suite 41
Hollywood Medical Centre,
85 Monash Avenue,
Nedlands, 6009

Tel: 6389 0244

Fax: 6389 0255

www.perthcolorectal.com.au

email: info@perthcolorectal.com.au

All correspondence to Hollywood

RESECTION RECTOPEXY FOR RECTAL PROLAPSE.

This general guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All your questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

What are the options.

A rectal prolapse can be repaired by operating either through the front of the abdomen, or *via* the anus (perineal approach).

The simplest perineal approach is the Delormes procedure. It has the advantage of being a simple operation that can be undertaken safely on even the most frail patient. The disadvantage is that the operation has a significant failure rate of 50% at five years. It can be re-done.

An abdominal rectopexy is an operation undertaken through the abdominal wall. As it is a bigger operation it carries greater risk. However, it is a better operation to fix the prolapse, with a failure rate of 1-2% at five years. There are two options. The first (resection rectopexy) is to pull up the rectum, remove some of the left hand bowel and join (anastomosis) it together again. There is a small risk (1-2%) of an anastomotic leak (see below). The second (sutured rectopexy) is to pull up and fix the rectum with a mesh, but not to resect any bowel. There is no anastomosis which means it is safer. However, about one third of patients are troubled by post-operative constipation.

Large bowel surgery has traditionally been by open surgery. It is now possible to offer selected patients laparoscopic (key hole) surgery. Laparoscopic surgery means the incisions are small, but once inside the abdomen a laparoscopic operation is almost identical to open surgery. That is why it is often called 'minimal access surgery'. The advantage of laparoscopic surgery is that the post-operative recovery is quicker.

In general patients who are fit are offered an abdominal operation. At present the consensus view is that the functional results of resection rectopexy are superior. Most patients having an abdominal resection rectopexy are suitable for laparoscopic surgery. For the sake of simplicity the remainder of this document is written as for laparoscopic surgery. Those who are less fit are offered a perineal approach.

What is involved.

Abdominal approach

The aim of the operation is to lift and fix the rectum and stop the prolapse. A segment of the bowel on the left of the abdomen is removed and joined up. The incision the small incision required for laparoscopic surgery plus one transverse additional low incision to extract the bowel. A general examination will then be performed to determine that there are no other abnormalities in the abdomen. The involved bowel will then be resected and the two ends joined together. The wound is then closed. There may or may not be skin sutures that have to be removed some 8-10 day later.

Perineal approach

The rectum is prolapsed down and the surplus length, either the mucosal lining only or the full thickness of the bowel, is excised. It is then sutured back together.

Will a colostomy be required?

A stoma (colostomy or ileostomy) is when part of the bowel is brought up onto the abdominal wall and a bag has to be worn. A stoma is not normally required as part of this operation.

Before the operation.

The anaesthetist will assess you and will discuss the various ways of controlling post-operative pain (see below). Prior to the operation you may be given a bowel preparation to empty and clean the bowel. You will have a number of routine blood tests.

It is important that we know every medical issue that might affect you. What may appear unimportant to you may be essential for us to know. In particular, we need to know all the drugs you are taking. You should bring them to the hospital in their original packet. Unless advised specifically to the contrary you should take all your drugs up to and including the morning of surgery. The exceptions to this are blood thinning agents, such as aspirin, plavix or warfarin, and diabetic drugs. These require special arrangements and must be discussed on an individual basis.

Once you are asleep various tubes and lines will be inserted into your veins, the bladder and through your nose into your stomach. These will be removed during the first 2-4 days following surgery.

Pain relief.

Proper pain relief is very important for both holistic and physiological reasons. Your post-operative recovery will be slower if you do not have adequate pain relief. Patients often have an understandable reluctance to take pain relieving drugs. This is a mistake and may increase post-operative complications. The principal that underlies all methods of pain relief is that the drugs work best if you anticipate the pain. A small quantity of the drug taken regularly (even if pain free at that time) will work better than waiting for the pain to occur and then taking a larger dose.

Before the operation the anaesthetist will offering you two types of pain relief. The first is a epidural anaesthetic. This requires a needle to be inserted into your back and drugs are given through a fine catheter. The alterative is 'Patient Control Analgesia (PCA). With this technique you press a button as and when you feel the pain and a small dose of the pain relieving drug is administered. The advantage of these techniques is that a small quality of the pain relieving drug can be administered on an on-going or regular basis and prevent the pain rather than treat it after it occurs. This is by far the most effective form of pain relief. Alternatively, regular injections can be administered. This is not as effective as they are usually administered after the pain has occurred.

After a couple of days adequate pain relief can normally be achieved by oral medication. Regular panadol, regardless of whether you have pain or not, is the foundation on which other medications are given. You should use this to provide background pain relief for a week after your operation. Additional, stronger painkillers and/or anti-inflammatory drugs can then be taken on top of the panadol for break through pain. Many strong painkilling medications contain morphine, codeine or a derivative of these drugs. One of the side effects of these drugs is constipation.

Post-operative care.

The remainder of this information sheet is directed to those having an abdominal approach. Patients having perineal operation have minimal pain, and make a very fast recovery. Many go home in three of four days.

The first 24 hours.

You may be nursed in a High Dependence Unit (HDU) where you are kept under constant observation. You will be attached to various monitors and numerous observations will be performed. The physiotherapist will visit you and will ensure your lungs are clear and free of secretions and exercise your legs.

The second 24 hours.

Much as day one, but you will be sat in a chair during part of the day.

Days three to five.

The tubes may be removed. You will progress from fluids to solid food. Your bowel will start to work, but maybe a little erratic and you may have some diarrhoea. You may have an episode of incontinence. Patients recover at different speeds and you should not be concerned if your progress appears slower than you anticipated.

Going home.

You will normally return home 7 - 10 days after your surgery, but this will vary with your progress and home circumstances. You will obviously be tired and you should plan to rest during each day. You should avoid domestic activities for at least the first three weeks. Sitting in a high backed chair can reduce the strain on your abdominal wound as it is easier to get up out of.

Recovery over the first six months.

Over the first six weeks you should gradually increase the exercise you take. You should avoid strenuous exercise for four weeks. 'Little but often' should be your aim and a short walk two or three times a day is better than one long walk. Gradually increase the distance you walk over the next few weeks. The surgical wound has almost returned to full strength at ten days so it is almost impossible to 'over exercise' yourself to the extent that you damage the surgical area. If you feel comfortable doing a particular activity then it is very unlikely you will do yourself any harm. In general it is sudden, unplanned movements that cause problems.

At six weeks you will be at least 80% recovered. As you start to feel better the likelihood is that you will overdo it and at this stage a couple of days of feeling well (and overdoing it) will be followed by a bad day as your body compensates. You have been warned! In general you should stop if you feel tired or if you feel pain. To fully recover to the point that you feel you have not had an operation will take three to six months, depending on your age and pre-operative fitness.

For medico-legal reasons you must not drive for four weeks.

Bathing and showering.

It is quite safe to get your wound wet with a shower or quick bath two or three days after your operation. However, long soaking baths with a Jeffery Archer novel should be avoided for at least three weeks as the wound will become soft and the scab may become infected. Adding salt to the bath will not help heal the wound and may make your skin dry and tight. After washing, pat the wound dry with a clean towel. A bath mat helps prevent slipping and a towel hooked around the bath taps can be a helpful lever when you try to get out. It can also be reassuring to have someone else in the house the first time you have a bath, even if you do not need help.

Sleep.

Changes in your routine, restricted movement, lack of exercise and wound discomfort will interrupt your normal sleep pattern or wake you during the night. Uninterrupted sleep is more valuable than 'cat-napping' so you may find it helpful to take a pain killer before you go to bed. You can resume sexual activity when this feels comfortable.

Eating.

Your appetite will not be good for some weeks after surgery and you may feel aches, bloating and indigestion after meals. These symptoms usually disappear as you become more active. You should take small, frequent meals with a good intake of protein (lean meat, dairy produce, fish *etc.*). A small amount of alcohol can improve your appetite and is not usually harmful.

The wound.

Wounds progress through several stages of healing. You may experience:-

- unusual tingling, numbness or itching sensations.
- a slightly hard or 'lumpy' feeling as new tissues form.
- pulling around the stitches or staples as the wound heals.

This is normal. Do not pull at any scabs as they act as a natural dressing and protect the new skin underneath. They will fall off when no longer required. You should seek help if any of the following occur:-

- the wound pain increases
- the wound becomes more reddened or swollen
- there is any discharge from the wound.

Work.

Your return to work depends on many factors, including your occupation, age and general health. You will definitely require one month off work, but many will require up to two months and some may require a third month. It is better to feel completely well before you return to work rather than have to take more time off a few weeks or days later because you have returned to work too early.

At six weeks you will be about 75-80% back to your pre-operative state. It will take three to six months to be 100% recovered.

Your post-operative bowel habit.

This operation removes the left hand bowel and fixes the prolapse. It is inevitable that your bowel habit will be disrupted in the post-operative period and this may include increased frequency, urgency and occasional episodes of incontinence of either flatus (wind) or faeces. Understandably patients find these problems distressing, but they do improve enormously

over the first three months and even further over the next six months. Some patients notice an ongoing improvement for up to two years. Depending on your individual circumstances it may be necessary to prescribe some tablets to help you.

Most patients who have incontinence prior to the operation will note a marked improvement after the surgery. In many cases they will become fully continent. For those who do not it is important to allow the anal sphincter muscles time to recover. Physiotherapy exercises to the pelvic floor may hasten your recovery. In a very small number of cases further surgery to help improve residual incontinence may be required. This would not normally be undertaken for at least three, and ideally six months.

Detailed information on how to improve your post-operative bowel habit is available on a separate advice sheet.

Surgical trainees.

Some patients may have part of their rectal prolapse operation undertaken by a surgical trainee. A trainee normally, but not always, under the direct supervision of the consultant. It is important that, as part of their training, trainees gain independent experience whilst consultant cover is still immediately available. There is a substantial body of surgical literature that shows the outcome of operations undertaken by properly supervised trainees is no worse than those performed by the consultant.

What can go wrong?

You will be undergoing a major operation. Major operations are sometimes complicated by adverse events. That said, the surgeons, anaesthetists and nurses caring for you have an extensive experience in what is, to them, a routinely performed operation.

The table below summarises the potential risks and complications. It is not intended to alarm as most patients will not have any complications. However, it is important that you appreciate that major surgery does carry risk and complications can and do occur. Although everything possible will be done to prevent the development of any complication, it is only possible to reduce, not eliminate, these events. This table is not exhaustive and if you have any concerns you should ask before you sign the consent form.

The majority of complications tend to occur in two groups. The first group are a direct effect of that particular operation. The major potential problem specific to an abdominal prolapse operation is a leak where the bowel was joined (the anastomosis). This is a serious complication (1 - 5% chance) and usually requires a second operation as an emergency. Normally this second operation will require a stoma. It may be possible to close this stoma at a second operation some months later. Up to one third of those developing an anastomotic leak will die as result of the leak.

The second group are general complications that can occur after any operation. The risk of these complications is greatly influenced by pre-existing medical conditions such as a previous heart attack, chronic illnesses such as diabetes, and smoking.

The best way to manage potential complications is to prevent them occurring in the first place. Hence the use of preventative, or prophylactic, treatment. It is important to correct any underlying medical conditions. For this reason it is essential you advise your doctors of all earlier operations and previous or ongoing medical illness. All your drugs should be brought to the hospital and shown to your doctors.

Risk	What happens	What may be done (options)
<i>General complications that may occur after any surgery</i>		
Clot in legs (DVT)	A clot forms in the legs. This may make the legs swell. The clot may break away into the lungs. This is a	Blood thinning drugs (heparin) started at the time of surgery. TED stockings. Calf pumps

	pulmonary embolus.	
Post-operative bleeding	Blood leaks into the abdomen or out through a drain	1. blood transfusion 2. re-operation
Wound infection	An infection, including the development of pus, occurs in the wound	Antibiotics started at the time of surgery. Drainage of any pus is required, and this may require another operation or drainage under radiological guidance
Intra-abdominal abscess	A collection of pus or infection blood in the abdomen	Drainage, either by surgery or under radiological guidance
Chest infection	A pneumonia develops	Antibiotics are required. A few patients require ventilation (in ICU)
Wound dehiscence	The wound opens up	Surgical repair within a few hours.
Incisional hernias through the wound	A weakness develops in the wound. The bowel then slips through the abdominal wall and a bulge appears. This usually occurs more than six months after surgery. The overall life time risk is >15%. This risk is increased in patients who have either chemo-therapy or radiotherapy, a wound infection or a chronic illness like diabetes or obesity.	A surgical repair, usually with mesh, is required.
Urinary tract infection	Bacteria enter the bladder	Antibiotics
Bladder may not empty	It is not possible to pass urine. As the bladder get full, the patient gets uncomfortable.	The catheter is re-inserted and removed a few days latter. Normally this solves the problem. Sometimes a catheter is required for 2-3 weeks. In men, prostate surgery may be required.
Vascular event	Stroke Heart attack	Each event managed on its own merits. Normally a period in ICU is required.
Death		In a fit person <2%. In other patients the risk is very dependent on pre-existing medical problems. A general estimate can be made by the use of risk prediction tables.

Complications that may occur after bowel surgery

Anastomotic leak	The join between the two ends of the bowel develops a leak. The risk for this operation <3 - 8%.	1. antibiotics alone 2. drainage under radiological guidance 3. further surgery, including an stoma if not already present
Post operative ileus	The bowel remains paralyzed for longer then the usual 3-4 days	1. a tube through the nose is inserted/left in the stomach 2. various drugs may be given 3. although it normally resolves in 3-5 days an ileus can occasionally be so prolonged that intra-venous feeding (TPN)is required.
Bowel blockage (adhesions)	Scar tissue in the abdomen blocks the bowel. This can occur within a few days of surgery, or many years latter (or any time in between). The life time risk is 15-20%	A NGT and IVI settles most. Some patients require further surgery.

What increases the risk of surgery

Examples

Why is the risk increased

Medical illness	Pre-existing general medical conditions such as endocrine disorders, heart attacks or strokes <i>etc.</i>	As far as possible pre-existing medical problems will be corrected prior to surgery
Previous surgery	All risks increased	Scarred tissue is normally of poor quality and does not heal well
Obesity		<ol style="list-style-type: none"> 1. poor quality tissue 2. poor mobilisation leading to increased risk of DVT, chest infection 3. poor blood supply so the risk of wound or anastomotic failure is much increased 4. extra strain on the wound, heart <i>etc</i>
Drugs	Examples include steroids, aspirin, blood thinning agents	Normally because they increase the risk of bleeding, infection or decrease the quality of wound healing
Diabetes		<ol style="list-style-type: none"> 1. ability to combat infection reduced 2. poor blood supply 3. slow healing
Smoking		Increased risk of anastomotic leak, infection, vascular events and thrombosis

Definitions

IVI	Intravenous infusion ('a drip')	
NGT	Nasogastric tube	A fine tube from through the nose into the stomach to drain the stomach and stop vomiting.
ICU	Intensive Care Unit	For very ill patients, or those requiring ventilation
Ventilation		Placing patients on a machine that does the breathing for them. A tube is placed through the mouth into the upper airway.