Fine-tuning indications for laparoscopic ventral mesh rectopexy

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For a long time, biofeedback has been the mainstay of treatment for obstructed defecation and internal rectal prolapse. A classical posterior rectopexy, requiring extensive rectal mobilization, results in autonomic nerve damage to the hindgut and results in severe constipation in about 50% of patients and therefore is considered obsolete for treatment of internal rectal prolapse [1]. The suggestion that internal prolapse was an incidental finding on defecography contributed to reducing interest in surgery for internal prolapse. The recent focus on functional outcomes in external prolapse surgery has revived interest in surgical management of internal rectal prolapse.

Laparoscopic ventral mesh rectopexy (LVR) was developed to improve outcomes of total rectal prolapse repair. This laparoscopic nerve sparing technique is safe and just as effective as classical posterior rectopexy. In our pilot series, constipation symptoms improved in 80% of patients and new-onset constipation was rare [2].

The Oxford Group developed a useful grading system to subclassify internal prolapse and demonstrated the relationship between high-grade intussusception within the anal canal (without overt prolapse), fecal incontinence and obstructed defecation.

Proctography is now an important part of the functional workup of a patient with fecal incontinence and obstructed defecation [3, 4]. The pathophysiology of obstructed defecation is complex, and often prolapse is accompanied by pelvic floor dyssynergia. LVR in patients with ODS and high-grade rectal intussusception provides resolution (or

significant improvement) of symptoms in about 70% of patients [3–5]. The functional results of LVR challenged the widely accepted view of the role of internal prolapse in ODS and introduced a reappraisal of the role of surgery not only in fecal incontinence, but also in ODS.

However, patients who could benefit from LVR for ODS must be more carefully selected. Despite appropriate workup and failed conservative treatment, about one in three patients will not benefit from the surgery [6]. Therefore, the research of the Oxford Group on LVR is a first step toward a better selection of patients who should undergo surgery. In this study, patients with high-grade intussusception and concomitant enterocoele had a significantly better functional outcome than patients with a horizontal rectal axis (drawer phenomenon).

In our own experience, patients with significant perineal descent and a denervated pelvic floor do not respond to LVR. LVR cannot correct pelvic floor descent and therefore the dissipation of the force vector to void the rectum persists.

LVR has gained widespread acceptance in total rectal prolapse repair: it restores anatomy and improves function (continence, constipation) in most patients. However, LVR is not a solution for any patient with ODS and internal prolapse. More studies are needed to explore and validate which patient benefits from ‘functional’ surgery.

Compliance with ethical standards

Conflict of interest The author declares that he has no conflict of interest.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

Informed consent For this type of study formal consent is not required.

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