

Laparoscopic ventral rectopexy for obstructed defecation syndrome

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Surgery for obstructed defecation (OD) caused by internal rectal prolapse has suffered a bad reputation. A classical posterior rectopexy, shown to denervate the autonomic supply of the rectum [1, 2], worsens constipation for 50% of patients and has been abandoned [3]. The novel nerve-sparing laparoscopic anterior or ventral rectopexy, which improves constipation in cases of external prolapse [4], may alter the way internal rectal prolapse is managed.

Your recent publication describing 17 patients who underwent a laparoscopic ventral rectopexy for OD syndrome causes us concerns [5]. The indication for surgery is not made clear. A variety of findings were shown by defecating proctography, including rectocele and enterocele, but only four patients had rectal intussusception. For most of the patients, the Longo OD syndrome score actually deteriorated and, inconceivably, the patients were happy with worse constipation postoperatively. The morbidity rate of almost 50%, including a rectal perforation, a small bowel perforation, a mesh infection and explantation, and a peripheral nerve injury, is unacceptable.

In our experience, rectoanal intussusception or a high-grade internal rectal prolapse plays the central role in OD. When OD is managed by dedicated functional colorectal surgeons through a specialist pelvic floor clinic, with multidisciplinary review of clinical, radiologic, and physiologic consideration, and careful case selection, the outcomes of anterior rectopexy need not be so poor.

In a similar 3-year period, we treated 75 patients with OD and high-grade (intra-anal) internal prolapse by laparoscopic anterior rectopexy, with 4% morbidity and 75% to

80% improvement in OD symptoms as well as significant reduction in median Wexner OD scores (13 to 4; $p < 0.0001$) [6]. Very similar results have recently been published by Slawik [7]. If internal prolapse surgery is to reestablish its reputation, we must do better.

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