

## Laparoscopic Ventral Mesh Rectopexy

### Introduction

We expect you to make a rapid recovery after your operation and to experience no serious problems. However, it is important that you should know about minor problems, which are common after this operation, and also about more serious problems that can occasionally occur. The section "**What problems can occur after the operation?**" describes these, and we would particularly ask you to read this. The headings from this section will also be included in the consent form you will be asked to sign before your operation.

### What is a Laparoscopic Ventral Rectopexy?

A Rectopexy is an operation to fix the rectum back into its normal anatomical position. This will be done via keyhole surgery (laparoscopic) where possible.

### Diagnosis

Before your surgeon decides to do this operation, you will have had several tests performed to assess your bowel properly.

**Endoscopy** to look at the inside of your bowel (a Flexible sigmoidoscopy, or a Colonoscopy),

**Anorectal physiology and ultrasound** this enables us to take some measurements of how your pelvic floor muscles are working.

**Proctogram** - an X-ray to show your bowel and pelvic muscles working, and to see how well supported your pelvic organs are.

**Physiotherapy** - You will have been given pelvic floor exercises to complete

You would also have dietary and bowel management advice before surgery is decided. This will all be useful for your recovery.

### Reasons for a Laparoscopic Ventral Rectopexy

**Intussusception:** This is when the external or internal lining of the bowel wall collapses in on itself during straining; this can then cause difficulty in passing a bowel motion.

**Enterocoele:** An enterocoele occurs when the bowel falls down from within the abdominal cavity into the pelvis often sitting in the gap between the rectum and vagina. This can cause pressure onto the rectum which may prevent you from emptying your bowel fully.

**Rectocoele:** is a bulge of the lower rectum towards the vagina due to a weakness in the tissues. This is more common in women than men and may be a result of child birth or repeated straining when opening your bowels.

You may experience feelings of a lump in your vagina and feel that you are not emptying your bowels completely. Leakage of small amounts of faeces with this condition is common.

**Obstructive Defecation Syndrome:** This is when you have the normal desire to defecate, but unfortunately you may have an impaired ability to completely empty your bowel.

In all of these conditions, you may find that you need to manually help your bowel to empty by applying 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.

## What does the procedure involve?

This operation is done laparoscopically (keyhole) under general anaesthetic, and takes about 1½ hours. There will be a small cut below your umbilicus (tummy button) and 2 to 3 other small cuts on your lower abdomen.

Inside the abdomen, the uterus (if present) is lifted forward, and a pocket is dissected between the front of the rectum and the vagina into which a piece of mesh is inserted, and stitched into place. The top end is fixed to the sacrum (end of the back bone). This mesh then splints the rectum into its proper position, lifting it up out of the pelvis, and prevents it telescoping in on itself as before, or any rectocele (bulge of the rectum into the vagina) or enterocele (bulge of bowel from higher up dropping into the pelvis between rectum and vagina). The vagina is then stitched to the mesh to prevent a vaginal prolapse

Enlargement of pelvic floor muscles

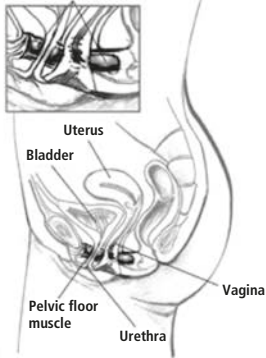


Diagram showing normal anatomy

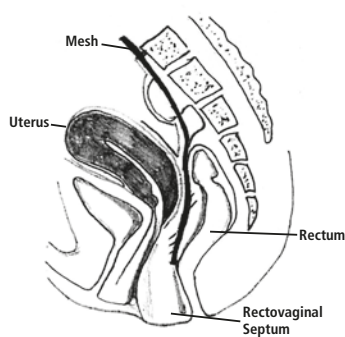


Diagram showing the mesh in place after surgery

## Alternative treatments

If you feel that you can manage with the symptoms then you may choose not to have surgery, however, if you change your mind then your surgeon would be happy to discuss your options with you.

## Before your surgery

While you are waiting for your operation, try and prepare yourself physically. Try and eat a healthy well-balanced diet including meat (unless vegetarian), fresh fruit and vegetables, and plenty of fluid i.e. 8-10 cups daily.

Take exercise such as walking, swimming etc. If you smoke, we strongly advise you to stop. If you would like help with this, see your GP or call the Stop Smoking Service on 0845 111 1142

### 1-2 weeks before your procedure

You will see a Pre-assessment nurse before your operation, for a health check. If you are taking any medication please bring them all with you. Your blood pressure will be checked, and you may have an ECG (heart trace) and a chest X-ray. You will also have blood taken. This information is all needed by the anaesthetist for planning your anaesthetic.

The Pre-assessment nurse will explain the admission process to you so that you know what to expect, and answer any questions you may have. If you live alone and have no friends or family to help you, please let us know, and we will try and organise necessary arrangements.

### The day of your procedure

You will usually be admitted to the ward on the morning of your operation. As with any surgery, you will need to stop eating 6 hours before surgery, though you may drink clear, still fluids until 2 hours before. You will be given an enema to empty your bowel before your operation. Your anaesthetist will see you before your operation, and the surgeon will also ask you to sign your consent form, and give you an opportunity to ask any further questions.

You will also be given stockings to wear, and a blood thinning injection, to help prevent blood clots forming. You will be asked to change into a theatre gown, so that you are ready for the Theatre staff to walk with you to Theatre. Your details will be checked at regular stages during the process.

## The time of your procedure

You will be collected by a member of the operating theatre team and walked down to the anaesthetic room (if you are able), you will then be asked to remove your dressing gown and shoes then get onto the theatre bed (trolley). Once on the trolley you will have some monitors placed on you to measure your oxygen levels, blood pressure and heart rate and rhythm in preparation for the anaesthetic. The anaesthetist will then insert a needle into your hand or arm to enable them to administer the anaesthetic. You will also have an oxygen mask placed onto your face.

## What happens after the operation?

It is important that you play an active part in your recovery. The aim is to optimise your recovery process and get you better quicker by reducing some of the risks of complications;

- Earlier mobilisation to prevent blood clots, chest infections etc. by sitting out of bed, and taking regular walks.
- Eat and drink as soon as you feel like it.
- Good pain relief to ensure that you are able to mobilise.

## Day of Operation (Day 0)

- You will wake up in Recovery, with an oxygen mask. Your blood pressure, pulse and oxygen levels will be monitored. You may sit up as soon as you are awake, and the nurses will make sure you have pain killers and anti-sickness medicine as you need. You may have something to drink as soon as you like. When you are comfortable and stable you will be taken back to your ward.
- You will have an intravenous drip, so that you do not become dehydrated, which will be taken out when you are drinking well. There will be a catheter in your bladder so that your urine can be measured.
- If you feel like it you may have something light to eat on the ward. You will be able to sit out of bed in a chair for a couple of hours later in the day.

- You need to do breathing exercises – breathe in deeply through your nose, and out through your mouth, 5 times, every hour.
- Exercise your calf muscles every hour by stretching and bending your legs, and rotating your ankles.

## Day 1- the first day after your operation

- You will continue to have pain killers and anti-sickness medicine as you require. Make sure the nurse looking after you knows if you have pain.
- Your catheter will be taken out
- You may eat a light diet of whatever you feel like, which you can gradually increase. Eat your meals sitting out of bed
- Continue deep breathing and leg exercises, and walk about as much as you can.

## DO s

Do take simple analgesia (i.e. paracetamol) and avoid opiate based analgesia (i.e. codeine) as this can constipate you.

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 six weeks after surgery, if your bowels are too loose. Patients differ enormously in their need for laxatives but it is important that for six weeks, your bowels are on the loose side of normal.

Do take exercise in the form of walking and swimming as soon as comfortable.

Do drink plenty of fluids after surgery.

Do expect that your bowel function will be different after surgery compared to before.

## DON'TS

Don't lift anything heavier than 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.

## Discharge from hospital

You will probably only need to stay in hospital a night or two. You may not have your bowels open before you go home, but you will be given Movicol or laxido (stool softener) to take on a regular basis. It is very important that you do not get constipated, and strain at all when opening your bowels, so that you do not strain the stitches holding the mesh in place, or cause pain.

## What problems can occur after the operation?

### Generalised operative risks include:

**Bleeding:** You can expect very little bleeding with this procedure, this is rarely a major problem.

**Wound infection:** You are very unlikely to develop a wound infection from this procedure, however, if you notice redness, swelling, discharge from your wounds, tell your nurse, or contact your GP if you have gone home.

**Chest infection:** To try and prevent this it is important you practice deep breathing, as explained below. Stopping smoking as long as possible before your operation will also help.

**Thrombosis (blood clot):** Deep vein thrombosis is a possible problem, but is uncommon. If you are at particular risk then special precautions will be taken to reduce the risk. Moving your legs and feet as soon as you can after the operation and walking about early, all help to stop thrombosis occurring.

### Procedure specific risks include:

This is relatively low risk surgery because bowel is not removed and the nerves to the rectum and genitalia are avoided.

**Recurrence:** Occasionally there can be recurrence for people who have repair of an external prolapse, but this is less than 2%, and rarely, people may experience no improvement following surgery, though for those with ODS, the majority experience a significant improvement, as do those with incontinence due to internal prolapse.

**Conversion to open surgery:** Occasionally, if you have had extensive abdominal surgery, you may not be suitable for laparoscopic surgery.

**Hernia:** Occasionally you may develop a bulge or hernia around one of the wounds, you may need a small operation to correct this.

**Mesh erosion:** Very rarely the mesh may erode through the bowel or wall of the vagina, this can happen months or even years following surgery. If this occurs you may need surgery to correct this.

## The risks of a general anaesthetic

General anaesthetics have some risks, which may be increased if you have chronic medical conditions, but in general they are as follows:

- **Common temporary side effects** (risk of 1 in 10 to 1 in 100) include bruising or pain in the area of injections, blurred vision and sickness, these can usually be treated and pass off quickly.
- **Infrequent complications** (risk of 1 in 100 to 1 in 10,000) include temporary breathing difficulties, muscle pains, headaches, damage to teeth, lip or tongue, sore throat and temporary problems with speaking.
- **Extremely rare and serious complications** (risk of less than 1 in 10,000). These include severe allergic reactions and death, brain damage, kidney and liver failure, lung damage, permanent nerve or blood vessel damage, eye injury, and damage to the voice box. These are very rare and may depend on whether you have other serious medical conditions.

## What should you do if you develop problems?

If you develop these problems the same day as you left the hospital please contact the ward you were discharged from. Alternatively please contact your GP.

## Do you need to return to hospital for a check?

You will be seen in an outpatient clinic in 6-8 weeks following your surgery, an appointment for this will be sent through the post to you.

## Who should you contact in an emergency?

Immediately after surgery you may contact the ward that you have just been discharged from, otherwise depending on your symptoms please contact your GP or Emergency Department.

The Trust cannot accept any responsibility for the accuracy of the information given if the leaflet is not used by Royal Devon staff undertaking procedures at the Royal Devon hospitals.

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