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Having surgery for rectal prolapse

Colorectal surgery

Information for Patients

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What is rectal prolapse ?

A rectal prolapse happens when the normal supports of the rectum (the lower end of the colon just above the anus) become weakened and the rectum drops down outside the anus.

This often happens because the anal sphincter muscle (the muscle of the anus) has become weak and there is difficulty in controlling the bowels with leakage of stool or jelly like material called mucus. While this condition occurs in both sexes, it is much more common in women than men.

Sometimes this only happens when you use the toilet (open your bowels), and it 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.

What are the symptoms of rectal prolapse ?

Rectal prolapse is not dangerous but it can be disturbing because:

- You can find it difficult to control your bowel movements.
- You may find you've passed some poo (faeces) when you didn't mean to. Or having some bright red blood or slimy mucus coming from your bottom.
- You might sometimes feel discomfort or pain
- You might need to push on your perineum to encourage bowel motions

Why does it happen?

There are several reasons why rectal prolapse may develop:

- A lifelong habit of straining on the toilet
- As a result of childbirth which may show later in life

- Rarely it may be due to a genetic (which runs in families) connective tissue illness
- As part of the natural ageing process when ligaments (connecting tissue which support the rectum inside the pelvis) weaken and the anal sphincter muscle loses strength.
- Sometimes it can be part of wider more general problems in the pelvic floor area and the muscular base which supports the bladder, rectum and genital area (private parts). In this case there may be problems of leaking wee (urine) and other pelvic organs may drop down out of normal position.
- Neurological problems (the brain, spine and nerves) may lead to prolapse.

How is rectal prolapse treated?

Although constipation and straining may contribute or add to the development of rectal prolapse, simply correcting these problems may not improve the prolapse once it has developed. There are two ways of operating for rectal prolapse:

- **Rectopexy -** Through the abdomen (tummy)
- The "**Perineal**" approach - Through the anus

For some patients who are suitable it may be possible to do the abdominal repair through key hole surgery (an operation done through a small hole or holes in the tummy with no need for a much larger cut as is the case with open surgery). The decision to recommend an abdominal rectal surgery or perineal surgery takes into account many factors, including other medical problems you may have, how physically fit you are , the size of the prolapse and the results of various tests.

How successful is treatment?

The surgery is successful in more than 50 people out of every 100. Success depends on many factors, including the health of your anal sphincter muscle before surgery; whether the prolapse is inside or outside of your body; and your overall health.

It is important to know that surgery is not a life long fix and the prolapse might happen again at some point in the future .

What are the risks?

Possible early complications of any major operation include:

- Bleeding requiring a blood transfusion or another operation
- Injury to nearby nerves or tissues
- Cardiac event or chest infection
- Blood clots in your lower leg (deep vein thrombosis or DVT), which could pass to your lung
- Wound infection, bruising, poor wound healing or weakness at the wound sites.
- Risk of death

Specific risks of a perineal repair of rectal prolapse

- Failure of the repair, resulting in rectal prolapse coming back
- Bleeding from the bottom
- Narrowing of the anal canal
- Unable to control or stop opening of bowels (faecal incontinence). This maybe temporary or permanent
- Leak from the join in the rectum (in Altemeier's Procedure). This is the most severe complication and can be life threatening, and you might need to have a "stoma" bag.

Pre-Assessment

After your surgeon puts your name in the waiting list, you will be invited for pre-operative assessment checks by an anaesthetist or pre-operative assessment nurse. This is on a different day before your surgery.

You will then receive a letter indicating the date of surgery and specific pre-operative instructions.

What shall I expect on the day of surgery ?

This operation takes from 1- 2 hours and can be done under general or spinal (back) anaesthesia, which will be discussed in details with you by the anaesthetist.

When you come to hospital you will need to have an enema to clear your lower bowel before surgery.

Then you will be taken to theatre and either put to sleep (general anaesthetic) or have the spinal (back) anaesthesia to numb your back passage area before to starting surgery

How will the surgeon fix my prolapse ?

Either the lining of the bowel **(Delorme's Procedure)** or a section of bowel (**Altemeier's Procedure**) that has prolapsed is removed and stitched back together from the inside.

The surgeon might leave a special sponge dressing in your back passage which will come out later when you use the toilet to open your bowels

There will be no visible wounds and no stitches will need to come out later

What happens after the operation?

After your surgery, when you wake up, a nurse or nursing assistant will check your blood pressure on a regular basis. You will be given pain relief to control any pain or discomfort, and laxatives to make sure you have a comfortable bowel motion. You can eat and drink as soon as you feel able to.

You will have compression stockings on your legs to prevent blood clots, and you will be encouraged to move around as soon as possible, it is recommended that you wear the stockings until you are fully mobile again. You should read our leaflets on reducing the risk of blood clots in hospital and at home. They are available from www.yourhealth.leicestershospitals.nhs.uk or ask a member of staff for a copy. You will be able to go home after you have passed wind and your bowels have opened.

How long will I stay in hospital?

Depending on your recovery, this may take few days. Eating foods rich in fibre, drinking plenty of fluids and moving around as soon as you feel able to do so, will all help you towards your recovery.

Do I need to come back to hospital after discharge?

Your stitches are internal and will dissolve over time. Your follow up plan will be written in your discharge letter.

When can I drive?

When you feel that you can make an emergency stop comfortably without hesitation, preferably not before 6 weeks

What do I need to do after I go home?

You may need to continue taking your pain relief medicines and laxatives when you go home. Recovery will be different for everyone, and can last anywhere from four to six weeks.

You need to avoid the following:

- Any heavy lifting or straining for 6 weeks
- Constipation
- Medications that are given into your bottom (rectum) such as enemas or suppositories

Try to keep your bowel motions soft by :

- Gradually eating more food containing fibre (fruits and vegetables)
- Drinking plenty of fluids
- Gentle daily exercise
- Mild laxatives and stool softeners as required
- You might need pelvic floor exercises to help strengthen your pelvic floor muscles (will be discussed by your surgeon)

You can contact us on 0116 2586853 or the pelvic floor nurses on 01162583775

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