Cochrane Library

Cochrane Database of Systematic Reviews

Surgery for complete rectal prolapse in adults (Review)

Tou S, Brown SR, Malik AI, Nelson RL

Tou S, Brown SR, Malik AI, Nelson RL.
Surgery for complete rectal prolapse in adults.
Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD001758.
DOI: 10.1002/14651858.CD001758.pub2.

www.cochranelibrary.com

WILEY

[Intervention Review]

Surgery for complete rectal prolapse in adults

Samson Tou[1], Steven R Brown[2], Ali Irqam Malik[3], Richard L Nelson[4]

[1]General Surgery, Queen Elisabeth Hospital, Norfolk, UK. [2]Surgery, Sheffield Teaching Hospitals, Sheffield S7, UK. [3]General Surgery, East Sussex Hospitals NHS Trust, Eastbourne, UK. [4]Department of General Surgery, Northern General Hospital, Sheffield, UK

Contact address: Samson Tou, General Surgery, Queen Elisabeth Hospital, King's Lynn, Norfolk, PE30 4ET, UK. samsontou@aol.com.

Editorial group: Cochrane Incontinence Group.
Publication status and date: Edited (no change to conclusions), published in Issue 1, 2010.

Citation: Tou S, Brown SR, Malik AI, Nelson RL. Surgery for complete rectal prolapse in adults. *Cochrane Database of Systematic Reviews* 2008, Issue 4. Art. No.: CD001758. DOI: 10.1002/14651858.CD001758.pub2.

ABSTRACT

Background

Complete rectal prolapse is a life-style altering disability that commonly affects older people. The range of surgical methods available to correct the underlying pelvic floor defects in complete rectal prolapse suggests that there is no agreement about the choice of the best operation.

Objectives

To determine the effects of surgery on the treatment of rectal prolapse in adults.

Search methods

We searched the Cochrane Incontinence Group Specialised Register (searched 10 January 2008), the Cochrane Colorectal Cancer Group Trials Register (searched 10 January 2008), CENTRAL (Issue 1, 2008), PubMed (1 January 1950 to 10 January 2008) and EMBASE (1 January 1998 to 10 January 2008). The British Journal of Surgery (January 1995 to January 2008) and the Diseases of the Colon and Rectum (January 1995 to January 2008) were specifically hand searched. The proceedings of the Association of Coloproctology meetings held from 1999 to 2007 were perused. Reference lists of all relevant articles were searched for further trials.

Selection criteria

All randomised or quasi-randomised trials of surgery in the management of adult rectal prolapse.

Data collection and analysis

Three reviewers independently selected studies from the literature searches, assessed the methodological quality of eligible trials and extracted data. The four primary outcome measures were: number of patients with recurrent rectal prolapse, number of patients with residual mucosal prolapse, and number of patients with faecal incontinence or constipation.

Main results

Twelve randomised controlled trials including 380 participants were identified and included in this review. One trial compared abdominal with perineal approaches to surgery, three trials compared fixation methods, three trials looked at the effects of lateral ligament division, one trial compared techniques of rectosigmoidectomy, two trials compared laparoscopic with open surgery and two trials compared resection with no resection rectopexy.

The heterogeneity of the trial objectives, interventions and outcomes made analysis difficult. Many review objectives were covered by only one or two studies with small numbers of participants. With these caveats in mind there is insufficient data to say which of the abdominal and perineal approaches has a better outcome. There were no detectable differences between the methods used for fixation during rectopexy. Division, rather than preservation, of the lateral ligaments was associated with less recurrent prolapse but more post-

operative constipation. Laparoscopic rectopexy was associated with fewer post-operative complications and shorter hospital stay than open rectopexy. Bowel resection during rectopexy was associated with lower rates of constipation.

Authors' conclusions

The small sample size of included trials together with their methodological weaknesses severely limit the usefulness of this review for guiding practice. It is impossible to identify or refute clinically important differences between the alternative surgical operations. Larger rigorous trials are needed to improve the evidence with which to define optimum surgical treatment for rectal prolapse: the results of one such trial are awaited.

PLAIN LANGUAGE SUMMARY

Surgery for complete rectal prolapse in adults

Complete rectal prolapse is when the lower part of the intestine (the rectum) comes through the anus. It is most common in the elderly, especially women, although why it happens is unclear. Rectal prolapse can cause complications (such as pain, ulcers and bleeding), and cause faecal incontinence (inability to control bowel movements). Surgery is commonly used to repair the prolapse. No studies comparing surgery with non-surgical methods were found. There was not enough evidence from the 380 participants in the 12 trials included in the review to show definitely which type of surgery works best. However, there is one trial which is ongoing which may provide some information in the future.