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[Intervention Review]

# Surgery for complete (full-thickness) rectal prolapse in adults

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## ABSTRACT

### Background

Complete (full-thickness) rectal prolapse is a lifestyle-altering disability that commonly affects older people. The range of surgical methods available to correct the underlying pelvic floor defects in full-thickness rectal prolapse reflects the lack of consensus regarding the best operation.

### Objectives

To assess the effects of different surgical repairs for complete (full-thickness) rectal prolapse.

### Search methods

We searched the Cochrane Incontinence Group Specialised Register up to 3 February 2015; it contains trials from the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, MEDLINE in process, ClinicalTrials.gov and the World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) as well as trials identified through handsearches of journals and conference proceedings. We also searched EMBASE and EMBASE Classic (1947 to February 2015) and PubMed (January 1950 to December 2014), and we specifically handsearched the*British Journal of Surgery* (January 1995 to June 2014), *Diseases of the Colon and Rectum* (January 1995 to June 2014) and *Colorectal Diseases* (January 2000 to June 2014), as well as the proceedings of the Association of Coloproctology meetings (January 2000 to December 2014). Finally, we handsearched reference lists of all relevant articles to identify additional trials.

### Selection criteria

All randomised controlled trials (RCTs) of surgery for managing full-thickness rectal prolapse in adults.

### Data collection and analysis

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

### Main results

We included 15 RCTs involving 1007 participants in this third review update. 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. One new trial compared rectopexy versus rectal mobilisation only (no rectopexy), performed with either open or laparoscopic surgery. One new trial compared different techniques used in perineal surgery, and another included three comparisons:

abdominal versus perineal surgery, resection versus no resection rectopexy in abdominal surgery and different techniques used in perineal surgery.

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. Given these caveats, there is insufficient data to say which of the abdominal and perineal approaches are most effective. 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 postoperative constipation. Laparoscopic rectopexy was associated with fewer postoperative complications and shorter hospital stay than open rectopexy. Bowel resection during rectopexy was associated with lower rates of constipation. Recurrence of full-thickness prolapse was greater for mobilisation of the rectum only compared with rectopexy. There were no differences in quality of life for patients who underwent the different kinds of prolapse surgery.

**Authors' conclusions**

The lack of high quality evidence on different techniques, together with the small sample size of included trials and 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. Longer follow-up with current studies and larger rigorous trials are needed to improve the evidence base and to define the optimum surgical treatment for full-thickness rectal prolapse.

## PLAIN LANGUAGE SUMMARY

### Surgery for complete rectal prolapse in adults

***Importance of the review***

Complete, or full-thickness rectal prolapse is when the lower part of the intestine (the rectum) becomes loose and telescopes out of the anus when straining. It should not be confused with haemorrhoids (or piles), which is when the veins around the anus swell up. Rectal prolapse is most common in older people, especially women, although its cause is unclear. Rectal prolapse can cause complications, such as pain, ulcers, bleeding and faecal incontinence (inability to control bowel movements). Surgery is a common treatment for repairing the prolapse.

***The main findings of the review***

Whether surgery is performed through a cut in the abdomen or a cut through the anus (known as a perineal approach), it makes no difference with regard to reappearance of the prolapse or appearance of postoperative complications. When surgeons perform the operation through a small hole in the abdomen (laparoscopic or keyhole surgery) recovery may be faster than for open abdominal surgery. When constipation is one of the main symptoms, bowel resection (removing part of the bowel) during prolapse repair may help. There was no difference in the results when different types of repair were used during the perineal (anal) approach.

***Adverse effects***

There was no particular concern about different types of surgery described in this review.

***Limitations of the review***

Although 15 studies were included in this review, many of them had different comparisons and some had poor methods, limiting the usefulness of the findings. However, longer follow-up of patients in these studies, together with results from ongoing trials, may provide some information in the future.