

Editorial

# An Age-Old Problem: The Surgical Treatment of Complete Rectal Prolapse

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## Dear Editor,

Complete rectal prolapse (CRP) is defined as a circumferential, full-thickness intussusception of all layers of the rectal wall beyond the anal verge [1]. It has an estimated incidence of 2.5 per 100,000 inhabitants, with a peak after the fifth decade of life and a female-to-male ratio of 10:1 [2].

Several etiopathogenetic theories have been described to date, including pelvic floor weakness, Douglas redundant sigmoid colon, pudendal nerve neuropathy, diastasis of the levator ani, or excessive rectal mobility, due to loose attachments to the sacrum. Interestingly, most patients report a history of chronic constipation or perineal injuries that are often associated with disorders of other pelvic floor compartments [3].

The initial pathophysiology theory, in which CRP would arise from rectal intussusception [4,5], has been contradicted by more recent works [6,7].

The patient may report a large spectrum of symptoms, with fecal incontinence in 88% and concomitant or sole constipation in 70% of cases [1].

In case of association with other structural abnormalities of the pelvic floor (e.g., enterocele, cystocele, rectocele), urinary incontinence may also be reported.

A further associated finding includes solitary rectal ulcer due to chronic excessive straining, which leads to mucosal trauma and consequent bleeding.

Diagnosis is often clinical, based on both patients' medical history and anoperineal examination. In particular, the latter provides useful information with regard to sphincter integrity as well as the severity of protrusion from the anal verge.

Conservative approaches have no role in the treatment of CRP, with the exception of rehabilitation of the pelvic floor; however, this is more indicated in the post-operative period [8].

There is still much debate on the ideal approach [9]. The goal of surgical treatment should be to solve both the prolapse and the underlying symptoms [10].

The surgical choice depends on several factors, such as the extent of the prolapse from the anal verge, the patient's age, gender and comorbidities. Surgeon's confidence with the type of procedure is a further important parameter to consider in decision-making.

Perineal procedures, such as the Delorme operation and the perineal sigmoidectomy according to Altemeier, which generally have a higher recurrence rate as compared to abdominal procedures, are often recommended in elderly patients that are unfit for major surgery and general anesthesia, or in young adults, to prevent the risk of impaired sexual function or fertility due to post-dissection pelvic adhesions [11,12].

Interestingly, the PROSPER trial showed no statistically significant differences between abdominal and perineal procedures in terms of recurrence rate, continence, bowel function, and quality of life [13].



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Besides the ventral mesh rectopexy (VMR), there are not many alternative abdominal procedures for the treatment of CRP. Moreover, the evidence for this technique is not sufficient to prove that it is the gold standard without considering the potential complications caused by the placement of a mesh in the pelvis [14]. Future studies are needed to assess the effectiveness of other minimally invasive techniques, especially robotic surgery, for the treatment of CRP [15].

Lobb et al. [16] have demonstrated the superiority of VMR over the sole suture rectopexy in terms of recurrence rate (3.7% vs. 8.6%, respectively), but these results should be confirmed by future randomized trials.

Although rectopexy is crucial to resolve patients' main complaint, there is a strong possibility of a new onset of postoperative constipation due to the lack of concomitant resection.

For this reason, old-fashioned procedures such as the Frykman–Goldberg are still considered to be valuable, with a high success rate.

Lastly, the decision to maintain an atonic rectum without any contraction capacity should be balanced against the risk of postoperative incontinence.

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