



Complete rectal prolapse: still a lot of work to do

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Dear Sir,

We thank Dr. Cirocco for his editorial [1] recently published in *Techniques in Coloproctology* regarding the never-ending story about the most appropriate surgical treatment for complete rectal prolapse (CRP). We have read it with great interest, because the management of a CRP is challenging for all coloproctologists interested in anatomico-functional disorders of the pelvic floor and we would like to share some of our thoughts on this topic. The PROSPER trial [2], the biggest randomized study on CRP, evaluated 293 patients and could not find any difference in outcome among abdominal and perineal approaches. Particularly it failed to demonstrate statistically significant differences, in terms of recurrence, between 213 (Delorme vs Altemeier), 78 (suture vs resection-rectopexy), and 49 (abdominal vs perineal) randomized patients. We recently published our experience regarding the Altemeier's approach [3] and we participated in the consensus statement of the Italian Society of Colorectal Surgery on the management and treatment of CRP [4]. Unfortunately, there is nothing new apart from a new-entry approach: laparoscopic ventral rectopexy. Its promising results are surely biased by series comprising internal and external prolapse, several types of fixations, use of meshes of different material, and different experience of the operating surgeon. The recurrence rate after Altemeier's procedure is up to 58% in the literature (40% in our series with a follow-up of 48 months), but what is a recurrence in these cases? Must we consider as recurrent a prolapse 3 cm in length after an operation that removed 50 cm of prolapsed colon and rectum or must we define recurrence only the reappearance of the same (or almost the same) length of external prolapse? In

our paper, we focused our interest more on the functional results than on the recurrence rate after Altemeier's procedure, because it is well known that the large majority of patients complain of moderate/severe disorders of defecation after surgical treatment for CRP, whatever procedure they have undergone. A parameter that is important in the surgical decision-making process is the removal or maintenance of the rectal reservoir. Altemeier's procedure removes the rectal ampulla, with a possible appearance or worsening of urgency or urge incontinence. On the other hand what is the point of maintaining an insensitive rectum without any capacity of contraction? In our series (as in several others), constipation got postoperatively better in 62% of patients, but incontinence improved in only 33%. Therefore, it is mandatory to inform the patient that, despite a satisfactory anatomical result, a high percentage of functional disorders occurs, particularly fecal incontinence. Additional treatments such as pelvic floor rehabilitation, transanal irrigation, as well as the implantation of a sacral nerve modulator in the postoperative period should be used during follow-up to correct remaining defecation disorders. When considering a new operation, the high possibility of a re-recurrence must be kept in mind. It is very interesting (and frustrating) to notice that the problem of the treatment of CRP, despite our increased knowledge of the physiology of the condition, is still unsolved, particularly as regards functional outcome after surgery. We thank Dr. Cirocco again for his longstanding interest in CRP, and we hope to begin a close collaboration with him and other specialists in this area to prepare a complete set of new and more specific investigations as well as tailored surgical and postoperative treatments and collective postoperative evaluation with the aim of improving our results.

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Compliance with ethical standards

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