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Editorial

The Rectal Prolapse Dilemma: Abundance of Adjectives[☆]

El dilema del prolapso rectal: abundancia de adjetivos

Approaches to the management of rectal prolapse have been the subject of discussion for more than a century. The critical variables are adverse events, life expectancy, and recurrence rates. Unfortunately, published articles on management of rectal prolapse often fail to enlighten us as to these respects. This is particularly true when we learn that published recurrence rates are 47% lower than the rates estimated by an independent review of the same data.¹ Moreover, it is unfortunate that editors continue to publish studies with a few-year follow-up,² when it is known that a 5-year recurrence rate of 7% can become 29% at 10-year follow-up.³

Described operations for rectal prolapse are myriad and include well-recognized eponymous associations. The literature on this rather uncommon condition has stimulated a disproportionate number of diverse operations, which include those directed at narrowing the anal orifice, obliteration of the pouch of Douglas, restoration of the pelvic floor, bowel resection by any number of routes, and suspension by various means. All have their advocates, but this editorial will focus only on some of the remote and recent history of suspension of the rectum with a transabdominal access.

Suspension of the redundant colon to the anterior abdominal wall had been advocated by Quénu⁴ as early as 1882 and by Ball⁵ in 1910; however, both of these procedures were sigmoid colectomy, not rectopexy. Suspension of the rectum to the sacrum and the sigmoid colon to the psoas muscle has been performed for more than 100 years. Carrasco,⁶ in his 1934 monograph, reported suturing the rectum to the sacrum, a concept resurrected by Cutait⁷ in 1959. The addition of a mesh for suspension of the rectum to the sacrum was proposed by Wells⁸ in his seminal work on the polyvinyl alcohol sponge in 1959, whereas Ripstein⁹ employed Teflon in 1965. An anterior suspension of the rectum to the posterior vaginal wall with sutures was described by Lloyd-Davies¹⁰ in 1949. The term *ventral* rectopexy first appeared in the literature in 1960.¹¹ Another *anterior* suspension was reported by Nigro¹² in 1970 as he designed a

sling-shaped mesh that suspended the rectum from the pubis. An *anteroposterior* rectopexy was also suggested for patients without overt prolapse.¹³

Up to that point, the addition of an adjective indicated the anatomical organ to which the rectum was suspended: the sacrum posteriorly, the vagina or pubis anteriorly. However, no reference was made as to where in the rectum the mesh was sutured. In fact, with the exception of the Lloyd-Davies and Deucher techniques, the mesh was sutured to the posterior mesorectum. In more recent years, one encounters publications that utilize the adjective *ventral* to indicate that a mesh was sutured to the *posterior* vaginal wall (and *anterior* rectal wall), yet suspended *posteriorly* to the sacrum.¹⁴ While this may well be a newer laparoscopic operation, it is certainly not new in our understanding of the history of surgery for rectal prolapse. If one can judge from the dearth of publications, this concept has been abandoned as an open operation for decades. In fact, a multivariate analysis of 667 individual patient data has shown that circumferential mobilization of the rectum is superior to anterior mobilization only in terms of recurrences (OR=4.68, P=.012).¹⁵

The critical concern is whether mesh rectopexy, including its ventral variant, will withstand the test of time, especially when details on surgical technique and data on adverse event rates emerge at scientific meetings.¹⁶ An example of the former is the placement of laparoscopic titanium staples to suspend a mesh to the sacrum, a technique that is no substitute for the standard of care of suturing. As for the latter point, erosion of the synthetic mesh resulting in perforation of the posterior vaginal wall is a devastating complication. This is unacceptable as the literature offers data suggesting that the addition of a mesh does not decrease recurrence rates when compared to suture rectopexy.³ Advocating or merely modifying an abandoned, antiquated operation simply because one can accomplish it laparoscopically negates the historical perspective that must be preserved.

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Conflicts of Interest

The authors have no conflicts of interests.

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Roberto Bergamaschi*, Marvin L. Corman
Division of Colon and Rectal Surgery,
State University of New York, Stony Brook,
Nueva York, United States

*Corresponding author.

E-mail address: rcmbergamaschi@gmail.com
(R. Bergamaschi).

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