Complete rectal prolapse, or procidencia, can affect the young and the elderly, and can cause distressing symptoms such as fecal incontinence in addition to the discomfort of the mass descending per anum. In spite of innumerable surgical procedures described and employed for correcting this disabling condition, there is no agreement on the choice of the operative procedure that can yield best results with minimum morbidity.

The primary cause of rectal procidencia remains unclear. Two concepts have prevailed over the years, viz., a sliding hernia through the recto-vesical or recto-vaginal pouch, or an intussusception of the proximal rectum through the anal canal due to functional disturbances of the pelvic floor or the ano-rectal sphincter musculature.1,2 This is compounded by predisposing factors such as multiparity,3 neurological illnesses4 or connective tissue disorders.5

The types of surgical approaches to rectal prolapse include:

a. anal encirclement
b. perineal resections with or without pelvic floor repair
c. transabdominal rectopexy or resection or both, by the open or the minimally invasive approach, and
d. creation of a reverse intussusception based on Devadhar’s concept of rectal prolapse being an intussusception of the proximal rectum through the anal canal.6

In spite of several hundred articles on this subject over the last decade, doubts remain on the following issues since prospective controlled trials with sufficient data are rare:7

a. Is surgical intervention better than nonoperative management? This becomes a consideration in the very elderly and the infirm
b. Is the abdominal or perineal approach better than the other?
c. Is one method of rectopexy superior to another?
d. Is the minimally invasive laparoscopic approach superior to the open procedure?
e. Is resection and pexy better than pexy alone?
f. What are the long-term consequences of these procedures?

There are at present no published data on the long-term outcome of nonoperative treatment and hence the first question remains unanswered. It is, however, unlikely that non-surgical options are likely to be favored by any patient faced with the distressing symptoms of rectal prolapse.

One study has compared the perineal and abdominal approaches.8 This showed that while no significant difference was seen as regards recurrence, the perineal approaches were associated with a higher incidence of persistent fecal incontinence. Rectal compliance was better with the abdominal approach.

Several types of meshes, such as ivalon, polyglycolic acid, polypropylene and polyglactin meshes, have been used for rectopexy. Studies have not shown significant advantage of any one type9,10,11 in obtaining cure, in reducing relapse rates, or in the occurrence of postoperative constipation.

Trials have compared the effect of preservation of the lateral rectal ligaments versus division of these. There is some evidence that preservation of the ligaments is associated with a greater incidence of recurrent prolapse but a lesser incidence of postoperative constipation.12

Recent studies have compared laparoscopic mesh repair with open mesh repair.13,14 There was no difference in recurrence rates, continence scores or rectal compliance. However, the mean operating time was significantly higher for the minimally invasive group. Nevertheless the significantly shorter hospital stay may compensate for this and there may be an overall cost benefit of the laparoscopic approach.

Resection versus rectopexy alone has remained controversial. Two trials addressed the results by comparing resection with suture or mesh rectopexy.15,16 Although residual fecal incontinence was low for both, postoperative constipation was significantly lower in the resection group.

Most procedures for rectal prolapse treat this condition as a form of sliding hernia and have concentrated on rectopexy or resection as a method of cure. Published series based on Devadhar’s concept are infrequent. In this issue of the Journal, Mehendale et al6 have published their experience over 25 years with creation of a reverse intussusception for treating rectal prolapse. Although their study was large and comprised 72 patients, the follow-up period is too short to judge true recurrence rates. Even within this period of 3-48 months, the authors have reported that 5 of 72 patients showed either a mucosal or a full-thickness recurrence. Their complication rates and success in minimizing sexual dysfunction parallel the best results of other abdominal approaches.6

The Cochrane review referred to in this article concluded that at present there is inadequate evidence to judge whether any one form of surgical intervention is...
more effective or safer than another type of intervention. Also, there is insufficient evidence to recommend use of abdominal versus perineal methods or open versus laparoscopic methods. It appears, therefore, that in most aspects of the surgical management of rectal prolapse, the jury is still out. When it returns, it will be to hear more evidence than to give a verdict.

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**References**