

<p>Author(s) P. Bachoo, M. Brazzelli, A. Grant.</p>
<p>Institution, city, country Health Services Research Unit, University of Aberdeen, UK</p>
<p>Title (type in CAPITAL LETTERS, leave one blank line before the text)</p> <p><b>COCHRANE SYSTEMATIC REVIEW OF SURGERY FOR RECTAL PROLAPSE IN ADULTS.</b></p> <p><u>Aims of study</u></p> <p>Complete rectal prolapse is a debilitating condition, which affects both the very young and the elderly and can cause faecal incontinence.</p> <p>The range of surgical methods available to correct the underlying anal sphincter or pelvic floor defects in complete rectal prolapse raises questions about the choice of the best operation.</p> <p>The aim of this review was to determine the effects of surgery on the treatment of rectal prolapse in adults.</p> <p>The following specific issues were addressed:</p> <ul style="list-style-type: none"> <li>- Whether surgical intervention is better than no treatment;</li> <li>- Whether an abdominal approach to surgery is better than a perineal approach;</li> <li>- Whether one method for performing rectopexy is better than another;</li> <li>- Whether laparoscopic access is better than open access for surgery;</li> <li>- Whether resection should be included in the procedure.</li> </ul> <p><u>Methods</u></p> <p>1. Search strategy</p> <p>Multiple electronic databases were searched to identify randomised trials using a comprehensive search strategy. Date of the most recent searches: March 1999. We also hand searched the British Journal of Surgery 1995-8, the Diseases of the Colon and Rectum 1995-8, and the proceedings of the Association of Coloproctology, meeting 1999.</p> <p>2. Selection criteria</p> <p>All randomised or quasi-randomised trials of surgery in the management of rectal prolapse.</p>

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### 3. Data collection & analysis

Two reviewers independently assessed the eligibility of studies, extracted data, and appraised the methodological quality of included trials. The three primary outcome measures were number of patients with recurrent rectal prolapse, or residual mucosal prolapse or persistent faecal incontinence.

### Results

Eight eligible trials were identified with a total of 264 participants. None of them included a group receiving no treatment, or anal encirclement, or Delormes procedure, or laparoscopic suture rectopexy, or laparoscopic resection rectopexy. One trial (20 participants) compared both perineal and abdominal resection rectopexy with pelvic floor repair; four trials (175 participants) compared different types of open rectopexy techniques; one trial (21 participants) compared laparoscopic with open mesh rectopexy; and two trials included comparisons between open resection rectopexy and rectopexy alone. There were no detectable differences in recurrent prolapse between abdominal and perineal approaches, although there was a suggestion that residual faecal incontinence was less common after abdominal surgery. 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 post-operative constipation, although these findings were found in small numbers. There were too few data with which to compare laparoscopic with open surgery. Bowel resection during rectopexy was associated with lower rates of constipation, but again numbers were small.

### Conclusions

The small number of relevant trials identified, together with their small sample sizes and other methodological weaknesses, limits the usefulness of this review for guiding practice. It was impossible to identify or refute clinically important differences between the alternative surgical operations. Larger rigorous trials are needed to improve the evidence with which to define optimum surgical treatment.