Presacral venous bleeding is an uncommon but potentially life threatening complication of rectal surgery. During the posterior rectal dissection, it is recommended to proceed into the plane between the fascia propria of the rectum and the presacral fascia. Incorrect mobilisation of the rectum outside the Waldeyer’s fascia can tear out the lower presacral venous plexus or the sacral basivertebral veins, causing what may prove to be uncontrollable bleeding.
Whenever PSB occurs, the first temporary manoeuvre is direct pressure at the point of bleeding together with aspiration of the accumulated blood.

Ligation of the internal iliac vein obstructs the drainage of the tributary veins, increasing the pressure in the PSVP and exacerbating the bleeding.
The possible strategies for dealing with this challenging life threatening complication

**Packing techniques**
- Traditional pelvic packing
- Silastic tissue expander
- Perineal Sengstaken–Blakemore tube
- Inflatable sterile saline bag
- Breast implant sizer
- Muscle tamponade

**Tacking techniques**
- Metallic thumbtacks

**Topical haemostatic agents**
- Haemostatic matrix + adsorbable haemostat
- Oxidised cellulose + cyanoacrylate glue
- Bone cement
- Bone wax

**Direct/indirect electrocoagulation and suture**
- Muscle fragment welding
- Spray electrocautery
- Argon beam coagulation
- Bipolar coagulation
- Circular suture ligation

**Other techniques**
Minimally invasive approaches have been increasingly applied to colorectal surgery and D’Ambra et al described a method to control PSB laparoscopically. The initial use of bipolar cautery or suturing is followed by cautery through an absorbable fabric mesh and if bleeding does not stop, indirect cautery through an epiploic appendix or a piece of omentum is performed. If the second step fails, a small scrap of bovine pericardium graft is finally tacked to the bleeding site.

Although a multitude of strategies have been employed successfully to control PSB, it is imperative to consider the stability of the patient when using potentially time consuming techniques to control such haemorrhage. When a patient begins developing the lethal triad of acidosis, coagulopathy and hypothermia, the surgeon must always consider packing of the pelvis to rapidly control haemorrhage and prevent further deterioration.
Algorithm for surgical management of presacral bleeding.

Compression and aspiration

Patient instability?
- Severe hypotension
- Hypothermia
- Coagulopath
- Acidosis

Algorithm for surgical management of presacral bleeding

NO  Is the bleeding site clearly identified?
- Muscle fragment welding.
- Topical haemostatic agents.
- Tacking.

YES  Packing with laparotomy pads
Different techniques can be applied in a single patient sequentially.

Thank You.