



# Rectopexies

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# Historical perspectives

## **Rectal Prolapse: A Historical Disease**

Descriptions dating back to ancient Egypt and Greek medicine

Major surgical developments in the 19th and 20th centuries

More than 100 procedures described

Persistent challenge:

- recurrence
- constipation
- incontinence
- morbidity



# Rectopexies



# Approach of pelvic anatomy

Correction of anatomy to help the larger proportion of patients

Carefull selection of patient and only after maximum conservative management

Minimal complications

Realistic expectations



# Why need new technique?

Problems with posterior mobilization

De novo constipation

Autonomic nerve injury

Sexual dysfunction

Obstructed defecation

Conceptual shift:

**“Less mobilization, better function.”**

# Laparoscopic ventral recto(colpo)pexy for rectal prolapse: surgical technique and outcome for 109 patients

A. D'Hoore, F. Penninckx

Department of Abdominal Surgery, University Hospital Gasthuisberg, Herestraat 49, 3000 Leuven, Belgium

Received: 6 July 2005/Accepted: 21 December 2005/Online publication: 9 October 2006

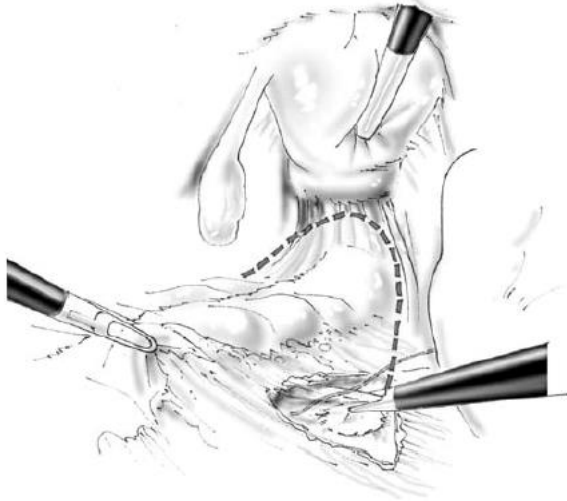


Fig. 1. Dissection starts at the sacral promontory with preservation of the right hypogastric nerve. The caudal extension of the peritoneal incision follows the dotted line.



Fig. 2. The deepest part of the fold of Douglas is retracted and incised. The rectovaginal septum is opened without any lateral dissection.



# Ventral mesh rectopexy

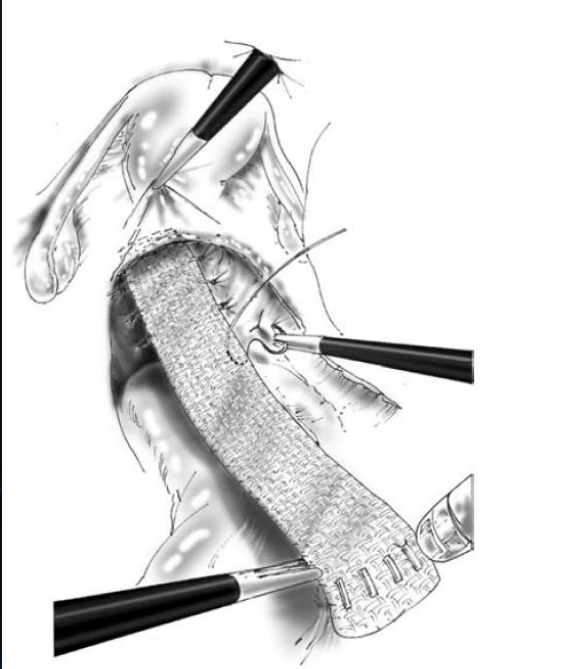
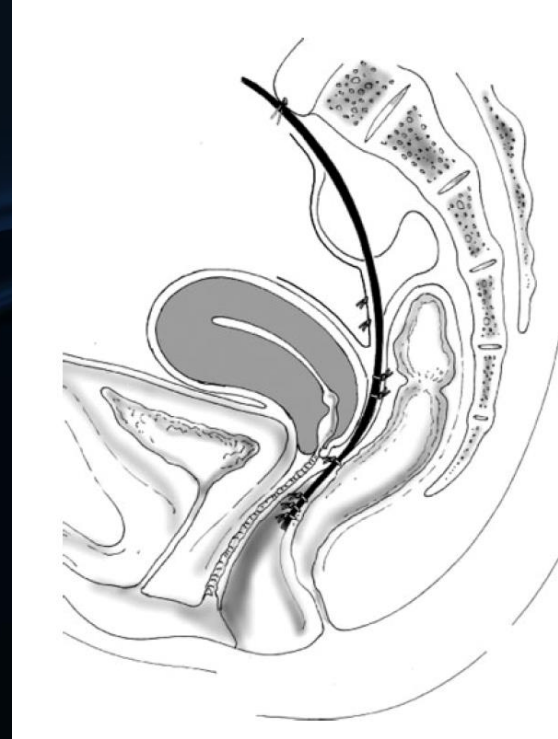


Fig. 3. A strip of polypropylene is sutured to the anterior aspect of the rectum and fixed without traction on the sacral promontory.



D'hoore et al. *surg Endosc* (2006) 20: 1919–1923, *British Journal of Surgery* 2004; 91: 1500–1505

# J. Meyer, E Liot , V Delaune, A Balaphas, B. Roche, G.Meurette, F Ris

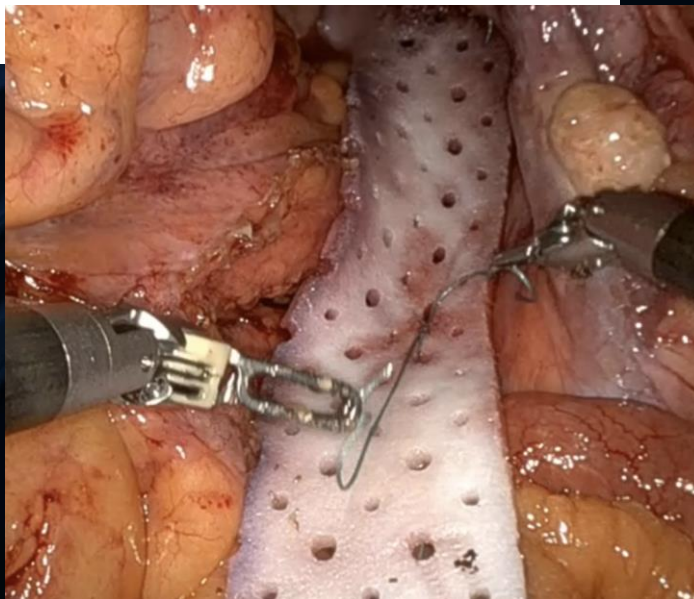
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DOI: 10.1111/codi.16799

## VIDEO CORRESPONDENCE



## Robotic mesh rectopexy for rectal prolapse: The Geneva technique—A video vignette





👑 It is a surgery for quality of life and comfort

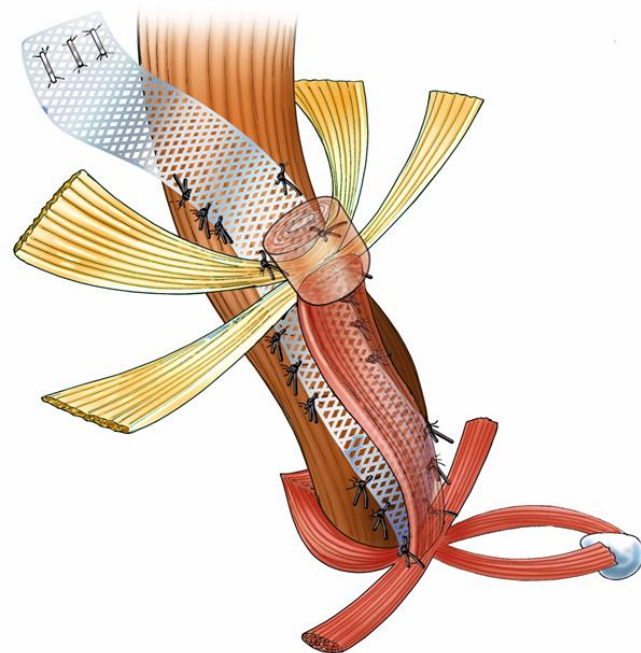
👑 It should have the lowest complication rate possible

# The role of VMR in prolapse surgery

## Recent Survey

60 yrs F; 4 cm FRP; previous HRT – no constipation

|                     | Overall      | Americas     | Austrial and NZ | Europe       |
|---------------------|--------------|--------------|-----------------|--------------|
| Posterior suture    | 31.6%        | 44.2%        | 18.4%           | 30.2         |
| Posterior mesh      | 6.4%         | 5.8%         | 4%              | 9.3%         |
| Resection rectopexy | 4.8%         | 9.3%         | 4%              | 1.2%         |
| <b>VMR</b>          | <b>56.7%</b> | <b>40.7%</b> | <b>68%</b>      | <b>62.8%</b> |
| Perineal approach   | 10.5%        | 7%           | 13.3%           | 11.6%        |



# Ventral Rectopexy: An International Expert Panel Consensus and Review of Contemporary Literature

William R. G. Perry, M.B.Ch.B., M.P.H.<sup>1</sup> • Peter Christensen, D.M.Sci.<sup>2</sup>  
Rowan J. Collinson, M.B.Ch.B.<sup>3</sup> • Julie A. Cornish, M.D., M.B.B.Ch.B., M.D.<sup>4</sup>  
André D'Hoore, M.D., Ph.D.<sup>5</sup> • Brooke H. Gurland, M.D.<sup>6</sup> • Anders Mellgren, M.D., Ph.D.<sup>7</sup>  
Carlo Ratto, M.D.<sup>8</sup> • Frederic Ris, M.D., Ph.D.<sup>9</sup> • Andrew R. L. Stevenson, M.B.B.S.<sup>10</sup>  
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On behalf of the Ventral Rectopexy Working Group\*

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Do we all speak about the same procedure?

Need for a contemporary evaluation of the role of the procedure and a description of its use in clinical practice

17 statements with high consensus

Poor quality of evidence,  
mainly retrospective case series

Significant heterogeneity in outcome  
reporting and outcome definitions between  
studies

# Need for standardisation ?

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## ORIGINAL ARTICLE

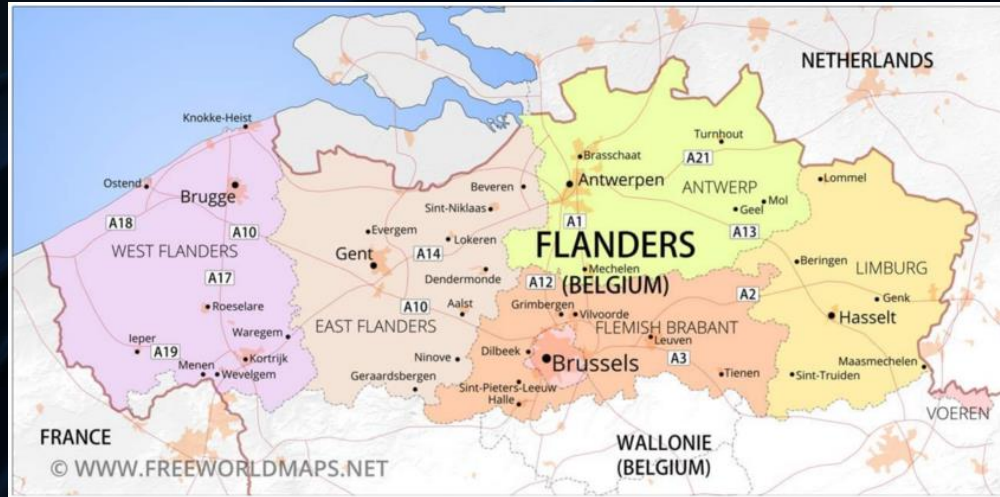


## Ventral mesh rectopexy: Variations in technique and care process. A multicentre study

Ellen Coeckelberghs<sup>1</sup>  | Ahmed M. Chaoui<sup>2</sup> | Mohamed Abasbassi<sup>3</sup> |  
Gabriele Bislenghi<sup>2</sup>  | Katrien Boon<sup>4</sup> | Michel Goethals<sup>5</sup> | Tom Hendrickx<sup>6</sup> |  
Bert Houben<sup>7</sup> | Marc Krick<sup>8</sup> | Frederic Meekers<sup>9</sup> | Paul Pattyn<sup>10</sup> | Pieter Pletinckx<sup>11</sup> |  
Deborah Seys<sup>1</sup> | Jasper Stijns<sup>12</sup> | Sylvie Van den Broeck<sup>13,14</sup> | Bart Van Geluwe<sup>15</sup> |  
Yves Pirenne<sup>16</sup> | Albert M. Wolthuis<sup>2</sup>  | Kris Vanhaecht<sup>1</sup> | André D'Hoore<sup>2</sup>

Explore the variation in care within and between Flemish hospitals in preoperative assessment, surgical indications, perioperative management and surgical technique for ventral mesh rectopexy (VMR)

14 hospitals



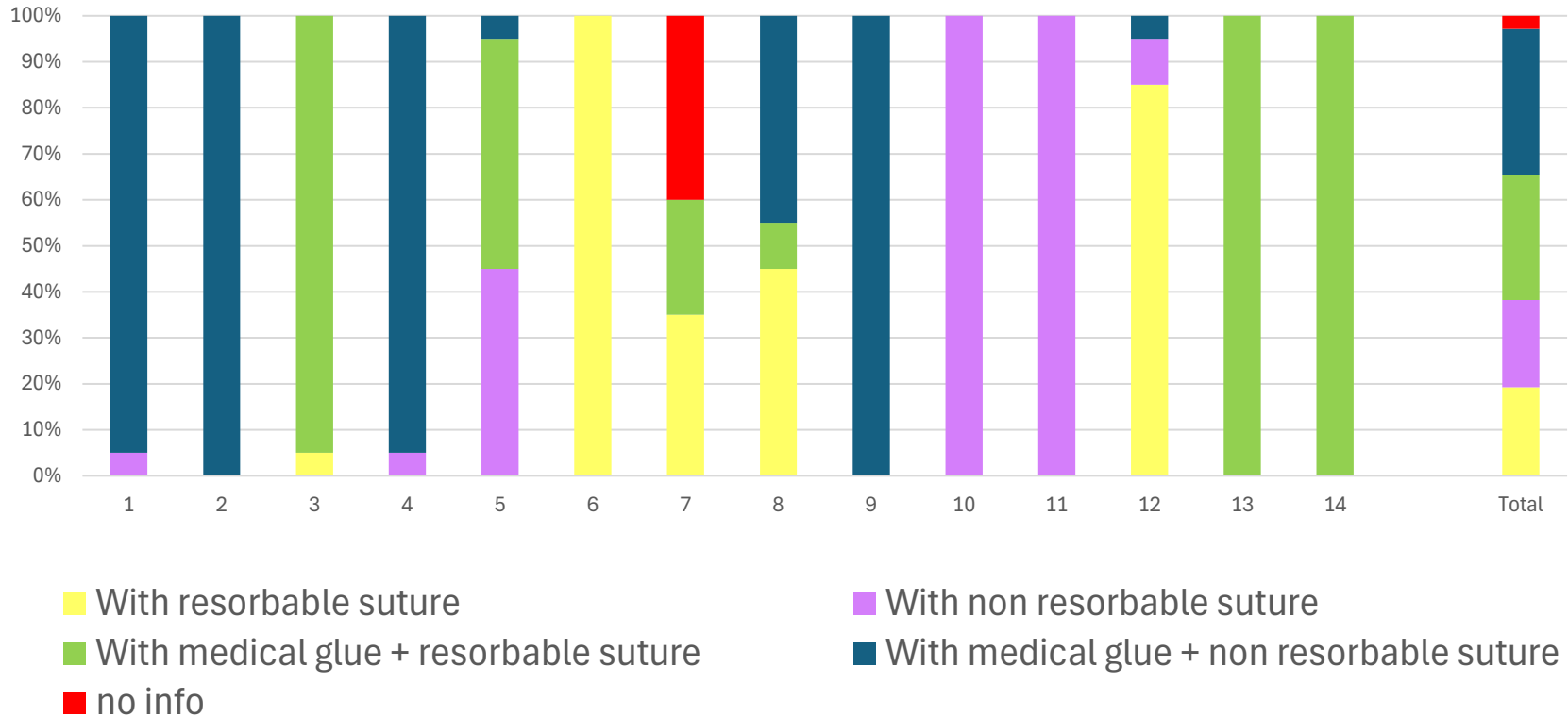
280 patients

Significant intra- and interhospital variation was observed in pre-operative work-up, indications, operative technique and postoperative management

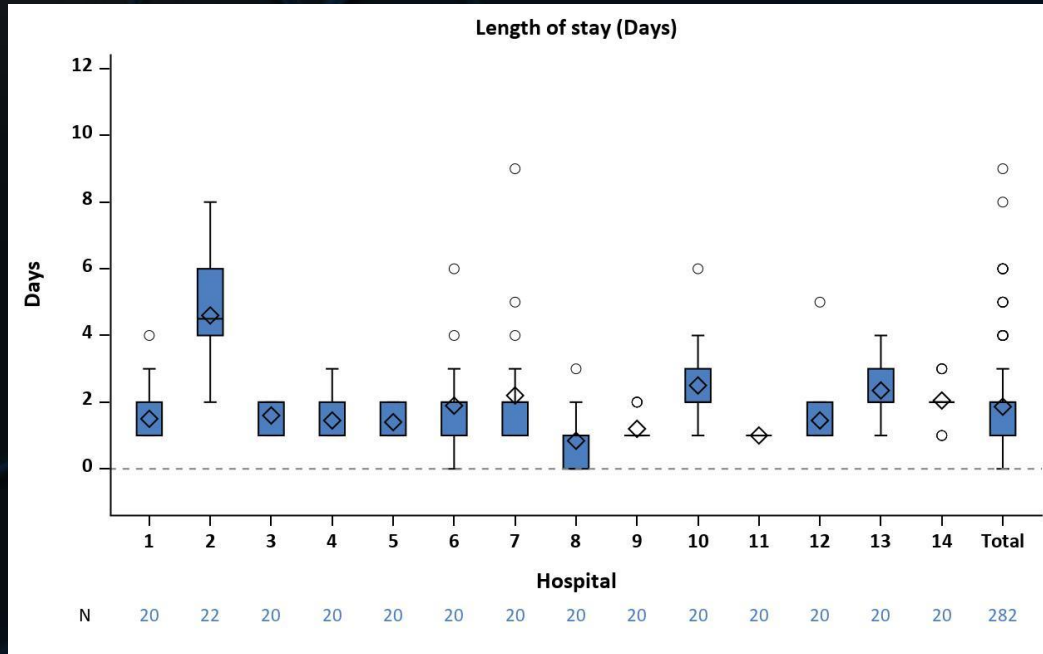
Minimally invasive in all cases,  
40% robotic and 60% laparoscopic

85.6% (n = 238) of all patients a lightweight mesh  
Diverging practices type of mesh fixation to the rectum.

# Fixation mesh – rectum: large variance



# Care pathway : LOS



**SDD: 3%**

**One night  
stay: 45%**

# Lack of standardization

We do not speak the same language...

Mesh fixation

Type of mesh, biologic vs synthetic

Robotic surgery?

# Urgent need to define a minimum data set to evaluate the quality of VMR

# Indications

- 👑 Incontinence
- 👑 External prolapse
- 👑 Internal prolapse
- 👑 Obstructed defecation
- 👑 Rectocele

# Indications (Statement 1)

VR is indicated for patients with full-thickness external rectal prolapse (ERP) and for selected patients with high-grade intussusception with symptoms of fecal incontinence and/or obstructed defecation who fail to respond to non-operative therapy (100% consensus).

# Indications (Statement 2)

VR is suitable when there are findings of multicompartment prolapse (100% consensus).

# VMR abdominal repair



**Good view on the tissue from above**



# Surgical approach (Statement 7)

VR should be performed as a minimally invasive procedure and can be done so as a day case with an enhanced recovery after surgery program (100% consensus).

# Robotic, comfort for the surgeon



RESEARCH



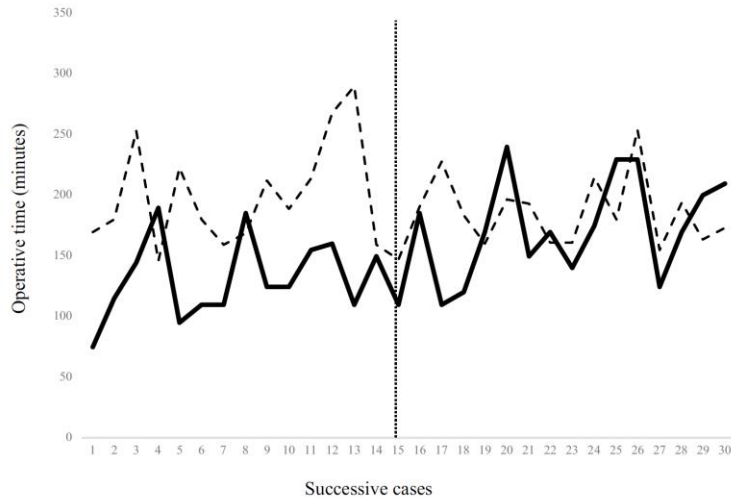
# Is robotic ventral mesh rectopexy for pelvic floor disorders better than laparoscopic approach at the beginning of the experience? A retrospective single-center study

Clotylde Dumas<sup>1</sup> · Julie Duclos<sup>1</sup> · Rémy Le Huu Nho<sup>1</sup> · Magali Fermo<sup>1</sup> · Emilie Gomez<sup>1</sup> · Aurélia Henin<sup>2</sup> · Camille Vaisse<sup>2</sup> · Nicolas Pirro<sup>1</sup> · Mathilde Aubert<sup>1</sup> · Diane Mege<sup>1</sup> 

RVMR is as safe and feasible as LVMR  
less conversion

Operative time is longer at the beginning of the robotic  
experience than laparoscopic approach

**Fig. 2** Operative time (minutes) according to the robotic (dotted line) and laparoscopic (continuous line) approach during all the consecutive cases. The threshold for achieving the same or a shorter operative time for RVMR than for LVMR was 15 procedures (small dotted line)



**Table 3** Perioperative results of 60 patients undergoing laparoscopic (LVMR) or robotic (RVMR) ventral mesh rectopexy

|                                    | LVMR<br>n = 30            | RVMR<br>n = 30 | <i>P</i> value |
|------------------------------------|---------------------------|----------------|----------------|
| <b>Intraoperative data</b>         |                           |                |                |
| Operating time (minutes)           | 150 [75–240] <sup>a</sup> | 182 [146–290]  | <b>0.0001</b>  |
| Conversion to open                 | 5 (17) <sup>b</sup>       | 0              | 0.05           |
| Associated procedures <sup>c</sup> | 5 (17)                    | 2 (7)          | 0.4            |
| Rectal mesh fixation               |                           |                | <b>0.0001</b>  |
| Surgical staple                    | 20 (67)                   | 0              |                |
| Stitches                           | 10 (33)                   | 30 (100)       |                |
| Promontory mesh fixation           |                           |                | <b>0.0001</b>  |
| Surgical staple                    | 28 (93)                   | 0              |                |
| Stitches                           | 2 (7)                     | 30 (100)       |                |
| <b>Postoperative data</b>          |                           |                |                |
| Length of stay (days)              | 5 [2–11]                  | 3 [2–10]       | <b>0.001</b>   |
| Morbidity                          | 1 (3)                     | 5 (17)         | 0.2            |
| Clavien-Dindo grade                |                           |                | 0.6            |
| I-II                               | 1 (3)                     | 4 (13)         |                |
| III-IV                             | 0                         | 1 (3)          |                |
| Postoperative VAS                  |                           |                |                |
| Day 1                              | 4 [0–9]                   | 2 [0–8]        | 0.07           |
| Day 2                              | 3 [0–6]                   | 3 [0–9]        | 0.9            |
| Day 3                              | 2 [0–8]                   | 1 [0–5]        | 0.9            |
| First bowel movement (days)        |                           |                |                |
| Flatus                             | 1 [0–7]                   | 1 [1–3]        | 0.6            |
| Stool                              | 3 [1–7]                   | 2 [1–5]        | 0.3            |
| Unplanned reoperation              | 0                         | 1 (3)          | 0.99           |

p < 0.05 was considered as significant (in bold)

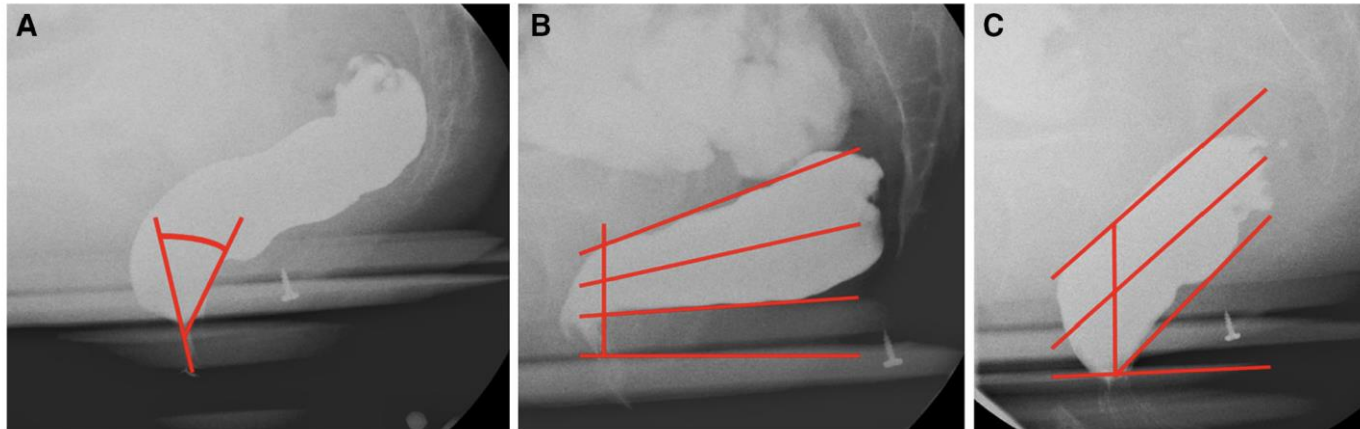
VAS visual analogic scale

<sup>a</sup>median [range]

ORIGINAL ARTICLE

# Rectal axis and enterocele on proctogram may predict laparoscopic ventral mesh rectopexy outcomes for rectal intussusception

F. Ris<sup>1,2</sup> · K. J. Gorissen<sup>1</sup> · J. Ragg<sup>1</sup> · M. P. Gosselink<sup>1</sup> · N. C. Buchs<sup>1</sup> ·  
R. Hompes<sup>1</sup> · C. Cunningham<sup>1</sup> · O. Jones<sup>1</sup> · A. Slater<sup>3</sup> · I. Lindsey<sup>1</sup>



**Fig. 1** Proctogram parameters. **a** Posterior anorectal angle. **b, c** Rectal *horizontal axis*

|                      |           |           |        |           |           |        |
|----------------------|-----------|-----------|--------|-----------|-----------|--------|
| Horizontal rectum    | 19 (0–48) | 10 (0–37) | <0.001 | 13 (6–21) | 10 (3–18) | 0.34   |
| No horizontal rectum | 20 (0–61) | 8 (0–48)  | <0.001 | 16 (3–22) | 4 (0–19)  | <0.001 |

possible association between enterocele as a marker for severe pelvic disease and good outcome of LVMR and an association between the rectal axis and surgical outcomes

Does it work or is it a fairy tale ?





# Laparoscopic Ventral Rectopexy for Faecal Incontinence: Equivalent Benefit is seen in Internal and External Rectal Prolapse

M. P. Gosselink • H. Joshi • S. Adusumilli • R. S. van Onkelen • S. Fourie •  
R. Hompes • O. M. Jones • C. Cunningham • I. Lindsey

**Table 3** Incontinence, constipation and quality of life of patients with high grade internal rectal prolapse (HIRP) or external rectal prolapse (ERP)

|                           | Preoperative | 1-year post  | <i>P</i> value |
|---------------------------|--------------|--------------|----------------|
| FISI                      |              |              |                |
| HIRP                      | 42 (30–61)   | 25 (0–56)    | <0.01          |
| ERP                       | 27 (0–61)    | 15 (0–61)    | <0.01          |
| Wexner constipation score |              |              |                |
| HIRP                      | 10.3 (0–23)  | 7.2 (0–21)   | <0.01          |
| ERP                       | 11.4 (1–30)  | 6.6 (0–19)   | <0.01          |
| GI-QOL                    |              |              |                |
| HIRP                      | 79 (32–130)  | 92 (41–136)  | <0.01          |
| ERP                       | 89 (24–136)  | 105 (33–144) | <0.01          |

# Surgical management of the rectocele – An update



M. Aubert<sup>a</sup>, D. Mege<sup>a,\*</sup>, R. Le Huu Nho<sup>a</sup>,  
G. Meurette<sup>b</sup>, I. Sielezneff<sup>a</sup>

Table 5 Data from the literature: laparoscopic abdominal surgical to treat rectocele.

| Reference                         | Number of patients | Postoperative morbidity (%) | Success (%)    | Recurrence (%) |
|-----------------------------------|--------------------|-----------------------------|----------------|----------------|
| Lyons et al. 1997 [61]            | 20                 | 0                           | 80             | —              |
| Solomon et al. 2002 [63]          | 20                 | 15                          | — <sup>a</sup> | 0              |
| D'Hoore et al. 2004 [10]          | 42                 | 0                           | 84             | 5              |
| Wong et al. 2005 [11]             | 20                 | 0                           | 100            | 1              |
| Wong et al. 2006 [12]             | 20                 | 0                           | 100            | at 6 months    |
| Freeman et al. 2007 [13]          | 20                 | 0                           | 100            | 6              |
| Formijne Jonker et al. 2008 [14]  | 20                 | 0                           | 100            | 6              |
| Maggiori et al. 2009 [15]         | 20                 | 0                           | 100            | 6              |
| Borie et al. 2010 [16]            | 20                 | 0                           | 100            | 6              |
| Consten et al. 2013 [17]          | 20                 | 12                          | 75             | 7.5 at 3 years |
| Mäkelä-Kaikkonen et al. 2016 [68] | 14                 | 7.1                         | —              | —              |
| Altomare et al. 2018 [70]         | 28                 | 3.6                         | —              | —              |

<sup>a</sup> Success not defined by the authors.

high success rate  
few complications

# Long-term Outcome After Laparoscopic Ventral Mesh Rectopexy

## *An Observational Study of 919 Consecutive Patients*

*Esther C. J. Consten, MD, PhD,\* Jan J. van Iersel, MD,\* Paul M. Verheijen, MD, PhD,\*  
Ivo A. M. J. Broeders, MD, PhD,\*† Albert M. Wolthuis, MD,‡ and Andre D'Hoore, MD, PhD‡*

2 units Leuven – Amersfoort

Pts treated between 1999 – 2013

N= 919

M/F ratio: 869:50

242 pts with external prolapse

Slawic  
Colorectal Dis 2008

|                                     | Total n = 919 (%) | Leuven n = 498 (%) | Amersfoort n = 421 (%) |
|-------------------------------------|-------------------|--------------------|------------------------|
| Preoperative fecal incontinence     | 344 (37.5)        | 121 (24.3)         | 223 (53.0)             |
| Grade 3 B&P                         | 18 (2.0)          | 3 (0.6)            | 15 (3.6)               |
| Grade 4 B&P                         | 326 (35.5)        | 118 (23.7)         | 208 (49.4)             |
| Postoperative fecal incontinence    | 102 (11.1)        | 50 (10.0)          | 52 (12.4)              |
| Grade 3 B&P                         | 27 (2.9)          | 17 (3.4)           | 10 (2.4)               |
| Grade 4 B&P                         | 75 (8.2)          | 33 (6.6)           | 42 (10.0)              |
| Preoperative obstructed defecation  | 496 (54.0)        | 269 (54.0)         | 227 (53.9)             |
| Postoperative obstructed defecation | 143 (15.6)        | 73 (14.7)          | 70 (16.6)              |
| ST                                  | 12 ST (1.3)       | 11 (2.2)           | 1 (0.2)                |

ERP indicates external rectal prolapse; IRP, internal rectal prolapse; symp, symptomatic, B&P, grading system as proposed by Browning and Parks; ST, slow transit.

**FU :33.9 months (range 0.4–143.6)**  
**Improvement of 80.2% of the symptoms**

# LVMR & Constipation

| Author   | Unit       | N  | F-up | Constipation better | Constipation worse |
|----------|------------|----|------|---------------------|--------------------|
| Boons    | Oxford     | 65 | 24m  | 83%                 | 2%                 |
| D'Hoore  | Leuven     | 42 | 62m  | 90%                 | 5%                 |
| Slawik   | Bristol    | 44 | 54m  | 91%                 | 5%                 |
| Formijne | Amersfoort | 36 | 30m  | 58%                 |                    |

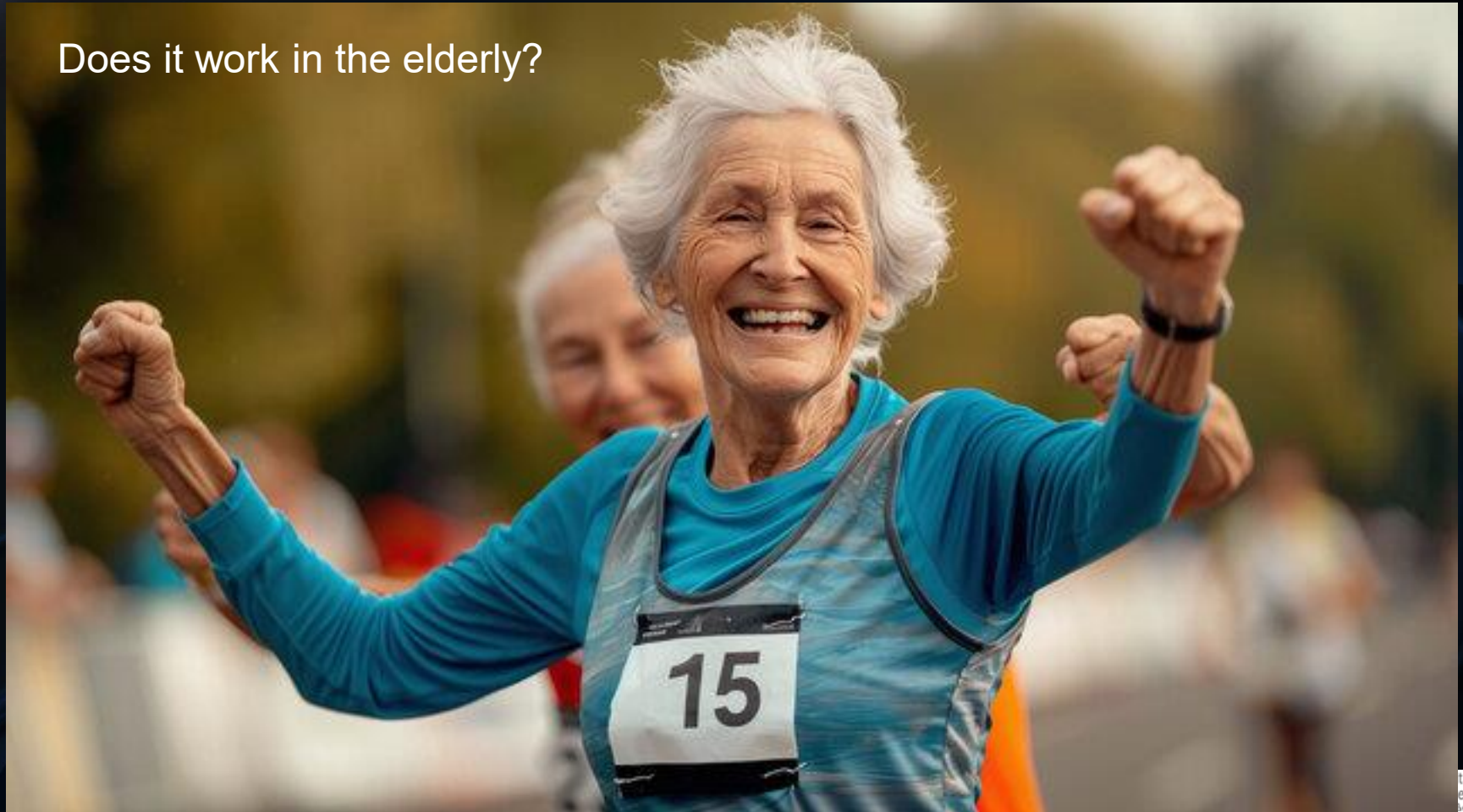
D'Hoore et al. BJS 2004

Slawik et al. Colorectal Dis 2008

Boons et al. Colorectal Dis 2010

Formijne-Jonkers et al Colorectal Disease 2013

Does it work in the elderly?



## **Safety of laparoscopic ventral rectopexy in the elderly: results from a nationwide database.**

Gultekin FA<sup>1</sup>, Wong MT, Podevin J, Barussaud ML, Boutami M, Lehur PA, Meurette G.

### Retrospective cohort analysis - national registry

4303 Lap Ventral Rectopexy

98.2% females

Group A : <70 years old

Group B : >70 years old, 1263 patients

Wijffels et al.  
Published Online 2014

| Parameter             | Group A   | Group B   | P value     |
|-----------------------|-----------|-----------|-------------|
| Length of stay (days) | 5.6 ± 3.6 | 4.7 ± 1.8 | $p < 0.001$ |
| Minor complications   | 5.0%      | 8.4%      | $p < 0.001$ |
| Major complications   | 0.7%      | 0.9%      | $p = 0.40$  |
| Death                 | 1 (0.07%) | 1 (0.03%) | $p = ns$    |

# Recurrences (Statement 12)

Recurrences after VR may occur and should be categorized by causation and extent. Revisional surgery is possible and can include redo VR (100% consensus).

# Recurrence Rates for LVMR

| Author    | Year | Unit     | N   | Follow-up | Recurrence |
|-----------|------|----------|-----|-----------|------------|
| Collinson | 2010 | Oxford   | 85  | 29m       | 2%         |
| D'Hoore   | 2004 | Leuven   | 42  | 62m       | 5%         |
| Slawik    | 2008 | Bristol  | 44  | 54m       | 0%         |
| Foucheron | 2012 | Grenoble | 175 | 74m       | 1%         |

D'Hoore et al. BJS 2004

Slawik et al. Colorectal Dis 2008

Collinson et al. Colorectal Dis 2010

Foucheron et al. DCR 2012

Slawik  
Colorectal Dis 2008

2/3 recurrences occur within first 3 years (Tjandra et al.)

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Pts treated between 1999 – 2013

N= 919

M:F 869:50, 242 pts with external prolapse

| Recurrence                                         | Total            |
|----------------------------------------------------|------------------|
| Duration* between surgery and recurrence           | 24.1 (1.0–139.4) |
| <i>Initial diagnosis</i>                           |                  |
| ERP                                                | 21               |
| IRP and/or symp. rectocele with/without enterocele | 47               |
| <i>Total recurrences</i>                           | 68               |

\*Median [minimum–maximum] duration in months between surgery and recurrence of the observed  
ERP indicates external rectal prolapse; IRP, internal rectal prolapse; pre-op, preoperative; FU, follow

Recurrence of  
7%

Slawic  
Colorectal Dis 2008

ORIGINAL ARTICLE

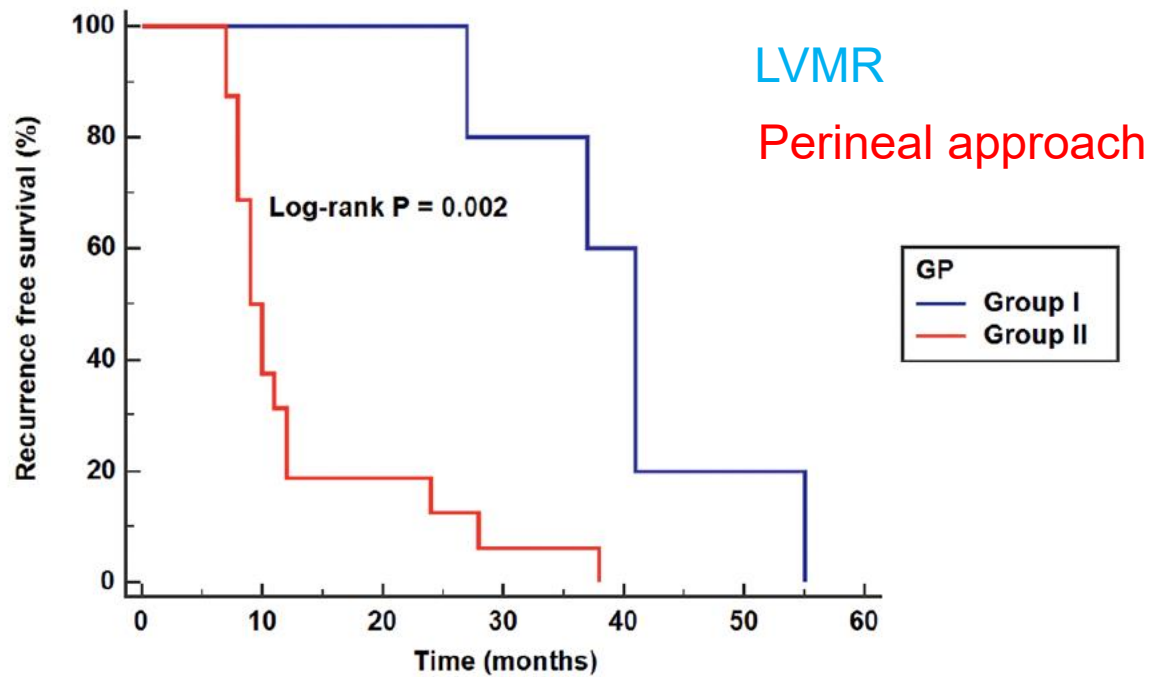


# Comparative study of laparoscopic ventral mesh rectopexy versus perineal stapler resection for external full-thickness rectal prolapse in elderly patients: enhanced outcomes and reduced recurrence rates—a retrospective cohort study

T. A. A. M. Habeeb<sup>1</sup> · M. Podda<sup>2</sup> · M. Chiaretti<sup>3</sup> · A. Kechagias<sup>4</sup> · J. B. Lledó<sup>5</sup> · Abd-Elfattah Kalmoush<sup>6</sup> · Fawzy M. Mustafa<sup>6</sup> · Mohammed Shaaban Nassar<sup>6</sup> · Mohamed fathy Labib<sup>6</sup> · Sobhy rezk ahmed Teama<sup>6</sup> · Mohammed Hassan Elshafey<sup>6</sup> · Hamdi Elbelkasi<sup>7</sup> · Mohamed Ibrahim Abo Alsaad<sup>8</sup> · Ahmed M. Sallam<sup>1</sup> · Hassan Ashour<sup>1</sup> · Mohamed Ibrahim Mansour<sup>1</sup> · Abdelshafy Mostafa<sup>1</sup> · Tamer Mohamed Elshahidy<sup>1</sup> · Ahmed m. Yehia<sup>1</sup> · Tamer Rushdy<sup>1</sup> · Alaaedin Ramadan<sup>1</sup> · Abd Elwahab M. Hamed<sup>1</sup> · Mahmoud Abdou Yassin<sup>1</sup> · Abd-Elrahman M. Metwalli<sup>1</sup>

group I: LVMR, n=250

group II: Perineal stapler resection, n=80



Number at risk

|                 |    |   |   |   |   |   |   |
|-----------------|----|---|---|---|---|---|---|
| Group: Group I  | 5  | 5 | 5 | 4 | 3 | 1 | 0 |
| Group: Group II | 16 | 6 | 3 | 1 | 0 | 0 | 0 |

**Fig. 7** Kaplan–Meier analysis showing median recurrence-free survival time

| Study                                        | Design                                               | N (LVMR)                                            | Follow-up*    | Recurrence at longest FU                                  | Mesh-related complications                                                 | Functional / QoL outcomes)                                                  |
|----------------------------------------------|------------------------------------------------------|-----------------------------------------------------|---------------|-----------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <b>D’Hoore 2004, Br J Surg</b>               | Single-centre prospective series;                    | 42                                                  | <b>61 mo</b>  | <b>2 late recurrences (~5%)</b>                           | NR                                                                         | 28/31 FI improved; ODS symptoms resolved in 16/19; 2 de-novo mild ODS       |
| <b>Faucheron 2012, Dis Colon Rectum</b>      | Single-centre prospective                            | 175                                                 | <b>74 mo</b>  | <b>2 x at 6 &amp; 24 mo;</b><br><b>5-yr recurrence 3%</b> | 1 rectal mesh erosion at 9 mo (0.6%); overall morbidity 5.1%, no mortality | Good long-term control of prolapse;                                         |
| <b>Consten 2015, Ann Surg</b>                | Multicentre, prospective database                    | 919                                                 | <b>10 yrs</b> | <b>8.2% (95% CI 3.7–12.7)</b>                             | Mesh-related complications in 18 pts (4.6%); vaginal erosion in 7 (1.3%,   | FI: 37.5% → 11.1%; constipation: 54.0% → 15.6% (both p<0.0001);             |
| <b>Barra / PEXITY 2025, Tech Coloproctol</b> | Single-centre long-term follow-up of original 175-pt | 62 analysed (>10 yrs after LVR; 175 original)       | <b>10-yr</b>  | <b>10.5% (17 pts); 5-yr recurrence 3%</b>                 | 0%                                                                         | Wexner FI score 4 (0–10); worse if recurrent RP. ODS score median 6 (3–12); |
| <b>Spivak 2025, Dis Colon Rectum</b>         | Single-centre comparative study                      | 135 VMR                                             | <b>113 mo</b> | <b>39% after VMR</b>                                      | NR                                                                         | Good Long-term QoL and functional scores                                    |
| <b>Singh 2022, Ann Surg</b>                  | Single tertiary centre;                              | 848 operated; 478 (56%) completed long-term results | <b>7 yrs</b>  | <b>NR</b>                                                 | NR                                                                         | 69% report bowel symptoms improved, 12% worse;                              |

# A fairy tale?

Maybe not...

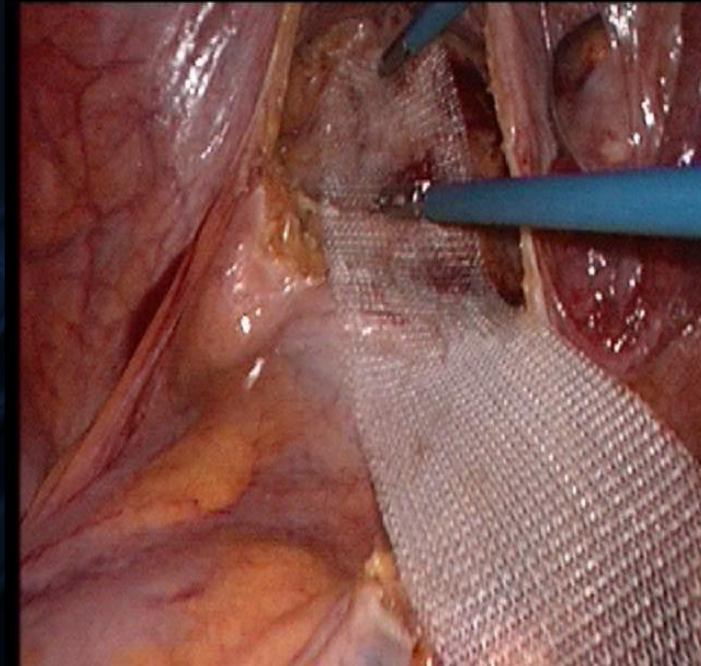




# Complications (Statement 10)

Postoperative complications after VR include prosthesis erosion, prosthesis infection, and de novo symptoms (100% consensus).

# Risk of the synthetic mesh





### Inside

#### Christmas TV listings

Enjoy your essential guide to what's on when in Seven Days



#### The **second** greatest story ever told?

A terrific read in the middle

#### Don't hurt your club

New chief exec urges fans not to boycott firms and vote to listen



SEE MAIL ONLINE

## EXCLUSIVE

# They said this surgery would change my life. It did. It left me in a wheelchair. At 29. With two young daughters



**TOGETHER**  
Leslie McConchey and daughters Morgan and Ella are coping with legacy of surgery

## REVEALED AT LAST THE TRUE TOLL OF NHS MESH SCANDAL

HUNDREDS OF WOMEN IN AGONY AFTER OP **SEE PAGES 4&5**

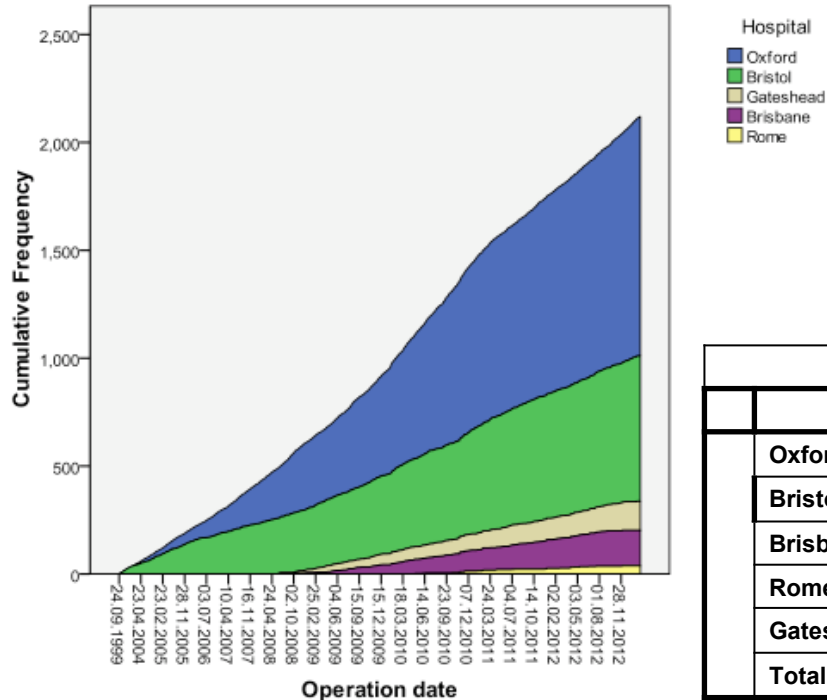
A close-up photograph showing a blue, woven mesh strip being held between the tips of two fingers. The mesh is rectangular and appears to be made of a fine, blue thread. The background is blurred, showing what might be a medical setting.

sky NEWS

Mesh scandal 'may be  
**worse than Thalidomide'**

# Mesh Erosion ?

Figure 1: Total Laparoscopic Ventral Rectopexies performed at the five institutions (Oxford, Bristol, Gateshead, Brisbane, Rome) between 1999 and 2013



| Hospital |           |      |       |
|----------|-----------|------|-------|
|          |           | N    | %     |
|          | Oxford    | 1179 | 53.5  |
|          | Bristol   | 674  | 30.6  |
|          | Brisbane  | 164  | 7.4   |
|          | Rome      | 49   | 2.2   |
|          | Gateshead | 137  | 6.2   |
|          | Total     | 2203 | 100.0 |



**TABLE 1.** Mesh types used and mesh erosions rates after laparoscopic ventral rectopexy

| <i>Mesh frequency (%)</i>      |                                                     | <i>Mesh erosions frequency, n</i> |
|--------------------------------|-----------------------------------------------------|-----------------------------------|
| Synthetic, N = 1764<br>(80.1%) | Polypropylene, n = 1325<br>(60.1%)                  | 23                                |
|                                | Polyester, n = 279 (12.7%)                          | 18                                |
|                                | Titanium-coated<br>polypropylene, n = 160<br>(7.2%) | 1                                 |
|                                | Total = 42                                          |                                   |
|                                | 3                                                   |                                   |
| Biological, N = 439<br>(19.9%) | Porcine dermal collagen,<br>n = 309 (14.0%)         | 0                                 |
|                                | Porcine intestine<br>submucosa, n = 30 (5.9%)       | 0                                 |
|                                | Total = 3                                           |                                   |

- 3 mesh removal plus colostomy
- 3 anterior resection

# Robotic removal of the mesh ...

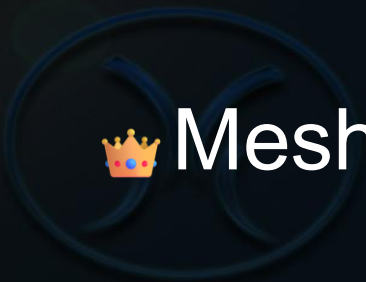


Removal of the mesh ?

Laitakari et al. Redo ventral rectopexy: is it worthwhile? Tech Coloproctol. 2021 Mar;25(3):299-307.

# Prosthesis (Statement 11)

Prosthesis-related complications should be managed by experienced surgeons at specialty centers (100% consensus).



👑 Mesh erosion is scary

👑 Maybe biologic is ...

# Synthetic Versus Biological Mesh-Related Erosion After Laparoscopic Ventral Mesh Rectopexy: A Systematic Review

Andrea Balla, Silvia Quaresima<sup>1</sup>, Sebastian Smolarek<sup>2</sup>, Mostafa Shalaby<sup>1</sup>, Giulia Missori<sup>1</sup>, Pierpaolo Sileri<sup>1</sup>

Department of General Surgery and Surgical Specialties "Paride Stefanini", Sapienza University of Rome, Rome, Italy; <sup>1</sup>Department of Surgery, Tor Vergata University, Rome, Italy; <sup>2</sup>Pelvic Oncology Fellow, Abertawe Bro Morgannwg University Health Board, Swansea, UK

**Table 2.** Number of cases in which was used any type of mesh

| Type of mesh                       | No. of cases employed (%) |
|------------------------------------|---------------------------|
| <b>Synthetic Mesh</b>              |                           |
| Polypropylene                      | 2,085 (59.02)             |
| Polyester                          | 850 (24.16)               |
| Titanium-coated polypropylene      | 160 (4.54)                |
| Synthetic mesh type not specified  | 422 (11.99)               |
| <b>Biological mesh</b>             |                           |
| Porcine dermal collagen            | 309 (70.4)                |
| Porcine small intestinal submucosa | 130 (29.6)                |

**Table 4.** Erosion mesh-related based on mesh type

| Erosions mesh-related       | Synthetic mesh, n (%) | Biological mesh, n (%) | P-value |
|-----------------------------|-----------------------|------------------------|---------|
| Rectal                      | 26 (0.73)             | -                      |         |
| Vaginal                     | 32 (0.90)             | -                      |         |
| Perineal                    | -                     | 1 (0.22)               |         |
| Recto-vaginal fistula (RVF) | 8 (0.22)              | -                      |         |
| Total                       | 66 (1.87)             | 1 (0.22)               | 0.012   |



## Mesh-related complications and recurrence after ventral mesh rectopexy with synthetic versus biologic mesh: a systematic review and meta-analysis

E. M. van der Schans<sup>1,2,3</sup>  · M. A. Boom<sup>1</sup>  · M. El Moumni<sup>3</sup>  · P. M. Verheijen<sup>1</sup>  · I. A. M. J. Broeders<sup>1,2</sup>  ·  
E. C. J. Consten<sup>1,3</sup> 

The incidence of mesh-related complications ranged between 0 and 2.4% after synthetic **versus 0–0.7% after biologic**

The risk of recurrence varied between 1.1 and 18.8% for synthetic VMR versus 0–15.4% for biologic (NS)

**HUGE variability in results**

# Type of mesh (Statement 9)

A biologic graft or a synthetic mesh can be used as the prosthesis for VR using an absorbable suture to attach it to the rectum (91% consensus).



*Article*

# Moving from Laparoscopic Synthetic Mesh to Robotic Biological Mesh for Ventral Rectopexy: Results from a Case Series

Farouk Drissi <sup>1,\*</sup>, Fabien Rogier-Mouzelas <sup>1</sup>, Sebastian Fernandez Arias <sup>2</sup> , Juliette Podevin <sup>1</sup>  
and Guillaume Meurette <sup>3</sup>

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# Controversy?

# Male rectal prolapse



# Risk

Narrow android pelvic dimensions and proximity to the pelvic nerve structures, particularly those relating to sexual function.

ORIGINAL ARTICLE

# Laparoscopic ventral rectopexy in male patients with external rectal prolapse is associated with a high reoperation rate

T. Rautio<sup>1,7</sup> · J. Mäkelä-Kaikkonen<sup>1,7</sup> · M. Vaarala<sup>2</sup> · M. Kairaluoma<sup>3</sup> ·  
J. Kössi<sup>4,5</sup> · M. Carpelan-Holmström<sup>6</sup> · S. Salmenkylä<sup>6</sup> · P. Ohtonen<sup>1,7</sup> ·  
J. Mäkelä<sup>1,7</sup>

success rate was  
high (83 %)

However, overall reoperation rate was high because of recurrent rectal prolapse as well as residual mucosal prolapse, suggesting that LVRP should be modified or combined with another abdominal or perineal technique

**Table 3** Reoperation

|                                               | All patients<br>No. 52 |
|-----------------------------------------------|------------------------|
| Reoperation for complication <i>n</i> (%)     | 2 (3.8)                |
| Reoperation for prolapse <i>n</i> (%)         | 7 (13.5)               |
| Re-LVRP                                       | 1 (1.9)                |
| Posterior mesh rectopexy                      | 2 (3.8)                |
| Resection rectopexy                           | 2 (3.8)                |
| Perineal resection                            | 1 (1.9)                |
| STARR                                         | 1 (1.9)                |
| Reoperation for mucosal prolapse <i>n</i> (%) | 8 (15.4)               |
| PPH                                           | 2 (3.8)                |
| HAL, RAR/THD                                  | 4 (7.7)                |
| Diathermy hemorrhoidectomy                    | 2 (3.8)                |

Nominal variables are reported as counts and percentages (in parentheses); Continuous variables are reported as the mean and standard deviation

*LVRP* laparoscopic ventral rectopexy, *STARR* stapled transanal rectal resection, *PPH* procedure for prolapse and hemorrhoids, *HAL* hemorrhoidal arterial ligation, *RAR* rectoanal repair; *THD* transanal hemorrhoidal dearterialization

# Male rectopexy (Statement 17)

VR can be considered as an option for surgical repair of rectal prolapse in male patients if the anatomical conditions support this approach (100% consensus).

# Conclusion :

## VMR is a good operation

Low recurrence

Well tolerated

Improves constipation and incontinence without resection

Possible minimally invasive with the robot RVMR

But still costly...



# Conclusion :

## But lack of standardization

Huge heterogeneity in surgery , outcomes and FU

Need for update data and a state of the art of the real life

# Urgent need to define a minimum data set to evaluate the quality of VMR.

## Plan to perform it at an European level!



# ESCP and ASCRS tripartite snapshot audit



**ESCP**  
**21<sup>ST</sup> SCIENTIFIC  
CONFERENCE**  
23-25 September 2026  
Prague, Czech Republic

 European Society of  
COLOPROCTOLOGY



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