Patient Information

NHS
Royal Devon and Exeter
NHS Foundation Trust

Anterior Delormes Procedure for the treatment of Rectocele

Introduction

We expect you to make a rapid recovery after your operation and to experience no serious problems. However, it is important that you should know about minor problems, which are common after this operation, and also about more serious problems that can occasionally occur. The section **"What problems can occur after the operation?"** describes these, and we would particularly ask you to read this. The headings from this section will also be included in the consent form you will be asked to sign before your operation.

What is an Anterior Delormes?

This is an operation performed via your back passage (anus) to repair the rectocele.

What is a rectocele?

A rectocele is a bulge of the lower rectum into the back of the vagina due to a weakness in the tissues. This may be a result of child birth or repeated straining when opening your bowels. It is also commonly found in people without symptoms. Symptoms may include:

- The feeling of a lump in your vagina and difficulty evacuating faeces with this sensation
- The feeling that you are not emptying your bowels completely
- You may leak faeces into your underwear without knowing
- You may need to place your finger into your rectum or apply pressure against your perineum to help empty your bowels.

Reasons for having an Anterior Delormes.

Many people have this condition and do not have many symptoms; however, if your symptoms have not improved with pelvic floor physiotherapy and are particularly bothersome then an Anterior Delormes Procedure may help relieve these.

Alternative treatments

You may choose not to have surgery as your symptoms are manageable or you may wish to continue with your pelvic floor physiotherapy. If your rectocele is very large then you may need to have a different operation that a member of your surgical team will discuss with you in clinic.

Diagnosis

Before your surgeon decides to do this operation, you will have had several tests performed to assess your bowel properly.

- **Endoscopy** to look at the inside of your bowel (a Flexible sigmoidoscopy, or a Colonoscopy),
- **Anorectal physiology and ultrasound** to take some measurements of your sphincter muscles
- **Proctogram** - an X ray to show your bowel and pelvic muscles working, and to see how well supported your pelvic organs are.
- **Physiotherapy** - You will have been given pelvic floor exercises to complete

You would have also dietary and bowel management advice before surgery is decided. This will all be useful for your recovery.

What does the procedure involve?

All the surgery is done through your back passage (anus) and therefore there are no stitches on the outside. The bowel lining on top of the bulge (rectocele) is stripped off and the muscle wall is stitiched together to strengthen the wall between bowel and vagina. This is usually completed as a day surgery.

What about the anaesthetic?

This surgery will be performed under general anaesthetic, you will be seen by your anaesthetist on the day of your surgery to discuss the anaesthetic in more detail.

What happens before the operation?

Prior to your admission you will have seen a member of the surgical team to discuss the surgery and its risks and benefits.

You will have a pre-operative assessment where you are likely to be examined by a practitioner, have bloods taken and be asked about your past medical history, previous surgeries and asked about any medications you may be taking. At times you may be asked to stop taking certain medications prior to surgery, these may impose an added risk to surgery such as blood thinning medications.

You will receive a letter detailing the date of your surgery, time and ward to report to for your admission. You will also be advised on what to bring to hospital with you.

Upon admission on to the ward you will be shown where to sit, where you will see a number of different people. You will be seen by a nurse who will take some information from you and will attach patient identification bands around your wrists or ankles. You will be given a gown to wear for theatre and anti embolism stockings to wear to help prevent blood clots. You will also be seen by a member of the surgical team who will go through the consent form for your procedure with you, an anaesthetist who will discuss your anaesthetic. You will also be given an enema to empty your bowel prior to surgery. Please stay on the ward so that you may be seen by all these people to avoid delays in your surgery.

When your theatre team is ready for you, a member of the theatre team will come to the ward, ; they will check a few details with you and then walk you to theatre if you are able. You will be taken into the anaesthetic room where you will be met by your anaesthetist. A member of the theatre team will ask you to lie on a theatre bed, and will attach a blood pressure cuff to your arm; a probe onto your finger to measure your oxygen levels and three round stickers attached to wires will be placed onto your chest to monitor your heart. You will also have a cannula placed into a vein on the back of your hand or arm; this allows the anaesthetist to administer the medications required for your anaesthetic.

What happens after the operation?

When you are awake and feel ready you will be given something to eat and drink. You will be encouraged to get up and use the toilet. When you are comfortable you will be allowed to go home (this is generally later that same day). Please make sure you have somebody to collect you as you will not be able to drive. You must also ensure that you have somebody to stay with you for 24 hours following your surgery whilst you are recovering from your anaesthetic.

You will be prescribed stool softeners as it is very important that you do not get constipated and strain to open your bowels as this would affect the success of the operation. You may find that you are slightly sore following your operation but simple pain killers such as paracetamol should help with this.

If your surgeon has placed an absorbent dressing into your bottom during surgery (your surgeon will advise you of this), you will pass this next time you open your bowels.

You can shower and bath after the operation and this is helpful in keeping the area as clean as possible. You may return to driving again 2-3 days after surgery when you feel you are able to complete an emergency stop, return to work

after 2 weeks but you should avoid any lifting for at least 6 weeks.

What problems can occur after the operation?

Bleeding – you may experience a small amount of bleeding from your bottom, this is more likely if you are taking blood thinning medications.

Infection – although relatively uncommon, due to the site of operation you are at risk of developing an infection, this is usually treated effectively with antibiotics.

Abscess formation – it is possible, although uncommon to develop an abscess, treatment for this would include antibiotics and/or surgery.

Recto-vaginal Fistula – this is when an abnormal connection between your rectum and vagina forms, allowing gas and stool to be passed through your vagina. This will need to be corrected by surgery.

Deep vein thrombosis (DVT) - is a possible problem, but is uncommon. If you are at particular risk then special precautions will be taken to reduce the risk. Moving your legs and feet as soon as you can after the operation and walking as soon as possible, all help to stop thrombosis occurring.

Failure to resolve symptoms – there is always a chance that this surgery will not resolve your symptoms, if this is the case then your surgeon will discuss further options with you in a follow-up clinic.

The risks of a general anaesthetic

General anaesthetics have some risks, which may be increased if you have chronic medical conditions, but in general they are as follows:

- **Common temporary side effects** (risk of 1 in 10 to 1 in 100) include bruising or pain in the area of injections, blurred vision and sickness, these can usually be treated and pass off quickly.
- **Infrequent complications** (risk of 1 in 100 to 1 in 10,000) include temporary breathing difficulties, muscle pains, headaches, damage to teeth, lip or tongue, sore throat and temporary problems with speaking.
- **Extremely rare and serious complications** (risk of less than 1 in 10,000). These include severe allergic reactions and death, brain damage, kidney and liver failure, lung damage, permanent nerve or blood vessel damage, eye injury, and damage to the voice box. These are very rare and may depend on whether you have other serious medical conditions.

What should you do if you develop problems?

In the first incidence you should contact your GP, your GP will then decide on the most appropriate treatment for you, and will be able to contact your surgeon if necessary.

Do you need to return to hospital for a check?

You will be sent an appointment to attend an outpatients clinic; this will usually be in 6-8 weeks following surgery.

Who should you contact in an emergency?

In the event of an emergency attend your local accident and emergency department. However, call 999 for an ambulance if:

- You are bleeding.
- Have chest pain
- Have shortness of breath.
- Are losing consciousness.