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Short Communication

Simultaneous Sarles and Transverse Perineal Support Operation for the Treatment of Occult Rectal Prolapse, Rectocele and Perineal Descent in Patients with Obstructed Defecation Syndrome

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Occult rectal prolapse is a pathological condition represented by circumferential rectal in-folding that doesn't pass beyond the anal canal [1]. This condition is more frequent in elderly women's and can be associated by rectocele (anterior rectal outpouching through insufficient recto-vaginal fascia) and perineal descent. The latter condition is characterized by the reduction of strength in perineal muscles with changes in force vectors during defecation. Perineal descent is frequent associated with other anatomical alterations, as described above, in the obstructed defecation syndrome (ODS) [2]. ODS is a debilitating condition where main referred symptoms are: prolonged straining, sensation of vaginal lump, incomplete evacuation, vaginal splinting, need for anal digitation or perineal manual support, difficult evacuation of hard stool.

Surgery represents the main form of treatment for patients with ODS associated with occult rectal prolapse, perineal descent with or without rectocele. Numerous procedures have been advocated for surgical correction [3,4].

Sarles procedure involves semi-circumferential mucosal sleeve resection and imbrication of the muscularis layer. This perineal approach, usually reserved for old and frail patients, is considered very safe improving at the same time constipation [5].

Transverse Perineal Support (TPS), first described by Renzi., *et al*. [6], is an interesting technique for perineal descent correction with the use of a biological mesh to reinforce the superficial transverse perineal muscle. TPS can be associated to other surgical procedures that aim at resect or suspend the prolapse.

The procedure is performed in lithotomy position under spinal anesthesia. Rectal cleansing with enema is performed the night before and the morning of surgery. Antibiotic prophylaxis (Cefazolin 2g + Metronidazole 500 mg e.v.) is administered 30 minute before incision. Prophylaxis for venous thrombosis is prescribed according to risk score. The patient is prepped and draped in standard fashion. The Epo Flier kit (Sapimed - Alessandria, Italy) is used for the procedure. The anoscope (Ø 34.3 mm) is inserted and the flange is fixed to the perineum. A dry tampon is inserted in the anus and retrieved to measure the amount of prolapse. Anterior rectal mucosa is put under traction with 6 allis clamps. Anterior mucosal sleeve resection is performed with bipolar energy. Recto-anal anal anastomosis, with muscularis embrocation, is fashioned with vicryl 2/0. An hemostatic tampon (Spongostan®) is left at the level of anastomotic rim. The flange is removed.

Skin antisepsis is performed. A bilateral skin incision at the level of ischial tuberosity is accomplished. Dissection by bipolar energy of the subcutaneous layer until periostium of the ischio-pubic rami is carried out. Two PDS 2/0 stay sutures are bilaterally passed in the periostium and left on kelly clamps. An arthroscopic trocar with a dissecting tip is advanced through right skin incision while doing counter traction with allis clamp. Once the trocar has reached the right skin incision the dissection tip is removed and a 0 prolene suture is passed in the provided hole and retrieved trough skin incision leaving the suture in the subcutaneous space. An 80 x 60 mm dermal porcine mesh (Tecnoss® Protexa supplied by MV Medical Solutions - Republic of San Marino) is rehydrated in a sterile saline solution for 30 minutes. Distance between the two ischial tuberosity and the high of perineal body are registered. The graft is fashioned on the recorded measurements. One end of the implant is passed with 0 prolene suture and withdrawn in place. Prothesis is secured to bony structures with bilateral "U" stitches. Skin incisions are closed in layers with vicryl rapid 3/0.

Patients are maintained on clear liquids for the first 24 hours, then are allowed to eat a low residue diet. An osmotic laxative is administered from first post-operative day. Patients are invited to walk freely in the ward. They are suggested to perform soft water cleansing of the skin incisions. Local application of antiseptic and healing cream (Ozonia 10® - Innovares, Sant'Ilario d'Enza, Italy) is prescribed for 2 to 4 weeks according to healing process. Patients are discharged after they passed stool. Clinical evaluation is scheduled at 7 days, 4 weeks, 3 and 6 months.

Compliance with Ethical Standards

Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent

Informed consent was obtained from all individual participants included in the study.

Conflict of Interest

The authors declare that they have no conflict of interest.

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