PROCEDURE

Rectal prolapse repair

Rectal prolapse repair is surgery that returns the rectum to its normal position and helps prevent it from slipping out again.

PURPOSE
Return the rectum to position and reduce recurrent prolapse

PROCEDURE TYPE
Therapeutic surgery; open or minimally invasive

WHERE IT IS DONE
Operating theatre

ANAESTHESIA
General anaesthesia for most repairs

HOW LONG IT TAKES
One to three hours

PREPARATION
Fasting; bowel preparation and medicine changes if instructed

RECOVERY
Usually one to several days; no driving initially

MAIN RISKS
Bleeding, infection, bowel injury, recurrence

RESULTS
Repair seen immediately; bowel function assessed during follow-up

Overview

Rectal prolapse repair is surgery to correct a rectum that has slipped from its normal position. The rectum is the final part of the large bowel. With full-thickness prolapse, part of its wall may pass through the anus.

The operation returns the rectum to the pelvis and helps keep it in place. Surgery can be performed through the abdomen or through the area around the anus, called the perineum.

An abdominal repair may be done through one larger incision or by keyhole surgery using several small incisions. Keyhole operations may be laparoscopic or robot-assisted. The rectum is usually secured to tissues near the lower spine in an operation called a rectopexy. Part of the bowel may also be removed if there is significant constipation or a long, loose section of colon.

Perineal operations remove or fold the prolapsed bowel through the anus. Common examples are an Altemeier procedure, which removes a segment of rectum and lower colon, and a Delorme procedure, which removes the inner lining and folds the muscle layer.

Why the procedure is performed

Rectal prolapse repair may be offered when prolapse causes discomfort, bleeding, mucus leakage, difficulty emptying the bowel, or loss of bowel control. It may also be considered when the prolapse repeatedly needs to be pushed back in or no longer stays inside.

Surgery is the main treatment that can physically correct full-thickness rectal prolapse. It may improve bowel control, but it cannot guarantee that constipation or leakage will completely resolve. Some bowel problems may have more than one cause.

Your surgeon will choose an approach based on the type and length of the prolapse, your bowel function, previous operations, general health, and personal priorities.

Who should and should not have it

Repair may be appropriate if you have confirmed full-thickness rectal prolapse and its effects are troublesome or are putting the exposed bowel at risk of injury. Testing may be needed to distinguish prolapse from haemorrhoids, internal prolapse, or other pelvic floor conditions.

It is not the right operation for every person. Elective surgery may be delayed if you have an active infection, an uncontrolled medical condition, or a problem that makes anaesthesia unsafe until it is treated. Medicines that affect bleeding may also require a planned adjustment.

An abdominal operation may place more strain on the body than a perineal repair. A perineal approach may therefore be considered for some people who are frail or have serious medical conditions. However, the prolapse may be more likely to return after some perineal repairs. The balance is individual.

A trapped prolapse that cannot be returned inside, particularly if the tissue becomes dark, very painful, or stops receiving blood, needs urgent assessment rather than routine elective planning.

How to prepare

Your treating facility's own instructions take priority because preparation differs by operation

and anaesthetic plan.

You may be asked to:

Give the team a current list of medicines, supplements, allergies, and previous reactions to anaesthesia. Do not stop a blood thinner like warfarin or apixaban on your own. The team that prescribes it and the surgical team should provide a safe plan.

Tell the facility if you become unwell before surgery, especially with fever, vomiting, diarrhoea, breathing problems, or a new infection.

- Stop eating and drinking at specified times
- Use a bowel-cleansing drink or enema
- Adjust medicines that affect bleeding or diabetes
- Arrange transport home and help during early recovery
- Stop smoking, if possible, to support healing

What happens during the procedure

Most repairs are performed under general anaesthesia, so you are unconscious and do not feel the operation. Selected perineal procedures may sometimes use spinal anaesthesia, which numbs the lower half of the body.

For an abdominal rectopexy, the surgeon releases enough of the rectum to return it to its normal position. The rectum is then secured near the sacrum, the bone at the back of the pelvis. Stitches or surgical mesh may be used, depending on the operation. If bowel is removed, the remaining ends are joined together.

For a perineal repair, the surgeon works through the anus. The prolapsed segment may be removed and the bowel rejoined, or the inner lining may be removed before the muscle wall is folded and tightened.

You may have a urinary catheter during or shortly after surgery. The team will monitor your breathing, blood pressure, pain, and bowel recovery after the anaesthetic.

Recovery and what to expect afterward

Pain is expected around the incisions or anus, but it should gradually improve. Perineal discomfort, bruising, and a feeling of pressure can occur. Your team will provide a pain-relief plan.

You may begin with fluids and move toward normal food as your bowel starts working. Passing wind is a useful sign of recovery. Follow advice about fluids and fibre. Straining can place pressure on the repair, so a stool-softening medicine may be recommended.

Walking is encouraged, often from the day of surgery. Avoid heavy lifting, forceful exercise, and repeated straining until your surgeon says the repair has healed enough. Care instructions differ between abdominal and perineal operations.

Do not drive while taking medicines that make you drowsy or while pain limits your ability to brake, turn, or react quickly. You should also meet any restrictions given by your surgeon or insurer. You will need someone else to take you home.

Time away from work depends on the operation and how physical your job is. Desk work may be possible sooner than work involving lifting or prolonged activity. Ask for a plan based on your duties.

Risks and possible complications

Possible risks include:

Some people need further treatment or another operation. Your surgeon should explain which risks apply to the proposed technique and whether mesh or bowel removal is planned.

- Bleeding, infection, or a reaction to anaesthesia
- Injury to the bowel, bladder, ureters, nerves, or nearby organs
- Blood clots in the legs or lungs
- The prolapse returning
- New or worsening constipation
- Ongoing bowel leakage or urgency
- Narrowing or leaking where bowel ends were joined
- Mesh infection, movement, or erosion if mesh was used

Results and follow up

The surgeon can usually tell immediately whether the rectum has been returned to its intended position. If bowel tissue was removed for laboratory examination, those results may take several days.

Bowel control and constipation take longer to assess. Swelling, temporary urgency, and irregular bowel movements can occur while the area heals. Improvement may continue over the following weeks or months.

Routine follow-up checks the wound, bowel function, pain, and signs of recurrence. Keep these appointments even if recovery seems straightforward. Contact the team between visits if symptoms are worsening rather than waiting for the next routine appointment.

Alternatives

Observation may be reasonable if the prolapse is limited, can be returned easily, and is not causing major problems. This avoids surgery but does not repair full-thickness prolapse, which may continue or worsen.

Managing constipation with fluids, fibre, appropriate medicines, and changes in toileting position can reduce straining. Pelvic floor therapy may improve muscle coordination or leakage. These measures can help symptoms but do not put a full-thickness prolapse permanently back in place.

Manual reduction means gently returning the prolapse inside. It can provide temporary relief but does not prevent it from coming out again.

Another surgical approach may also be an alternative. Abdominal repair often provides stronger support but usually requires general anaesthesia and abdominal incisions. Perineal repair avoids abdominal surgery and may involve less physical stress, but recurrence can be more likely with some techniques. Mesh-free and mesh-based rectopexy also have different potential benefits and complications.

When to call your healthcare team

Contact your surgical team promptly for increasing pain, persistent vomiting, fever, worsening wound redness, pus, difficulty passing urine, or bleeding that is more than a small amount. Also call if you cannot pass stool or wind as expected, your abdomen is becoming more swollen, or the prolapse returns.

Seek emergency help for chest pain, severe breathing difficulty, fainting, heavy bleeding, or sudden severe abdominal pain. A prolapse that is trapped outside and becomes very painful, dark, or dusky also needs emergency assessment.

Mild soreness, small spots of blood, and temporary changes in bowel habits may occur during routine recovery. Follow the discharge instructions for what your facility expects after your

specific operation.

Common questions

Will I be asleep?

Most rectal prolapse repairs use general anaesthesia, so you will be asleep. Some perineal operations may be possible with spinal anaesthesia.

Can I drive home?

No. Arrange for another adult to take you home. Do not drive until pain, movement, and any sedating medicines no longer affect safe control of a vehicle.

How painful is it?

Pain varies by approach. Abdominal incisions may feel sore when moving, while perineal surgery may cause pressure or discomfort around the anus. Pain should become more manageable as healing progresses.

When will I know if it worked?

The surgeon can confirm the repair after the operation. Whether bowel control and constipation improve becomes clearer over weeks or months.

Will the prolapse come back?

It can recur after any repair. The chance is influenced by the operation, tissue support, bowel habits, and other health factors. Avoiding straining and following recovery instructions may help protect the repair.

Sources

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