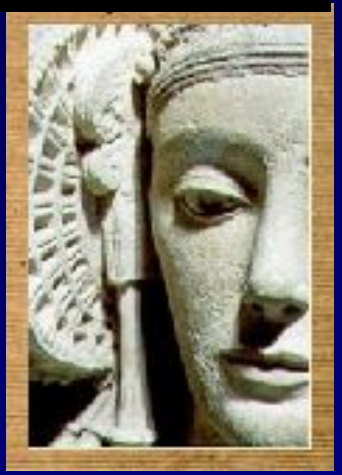
TRATAMIENTO QUIRÚRGICO VÍA ABDOMINAL PROLAPSO RECTAL



Unidad Coloproctología

Servicio Cirugía General y Ap.Digestivo
Hospital General Universitario de Elche

Dr. Antonio Arroyo

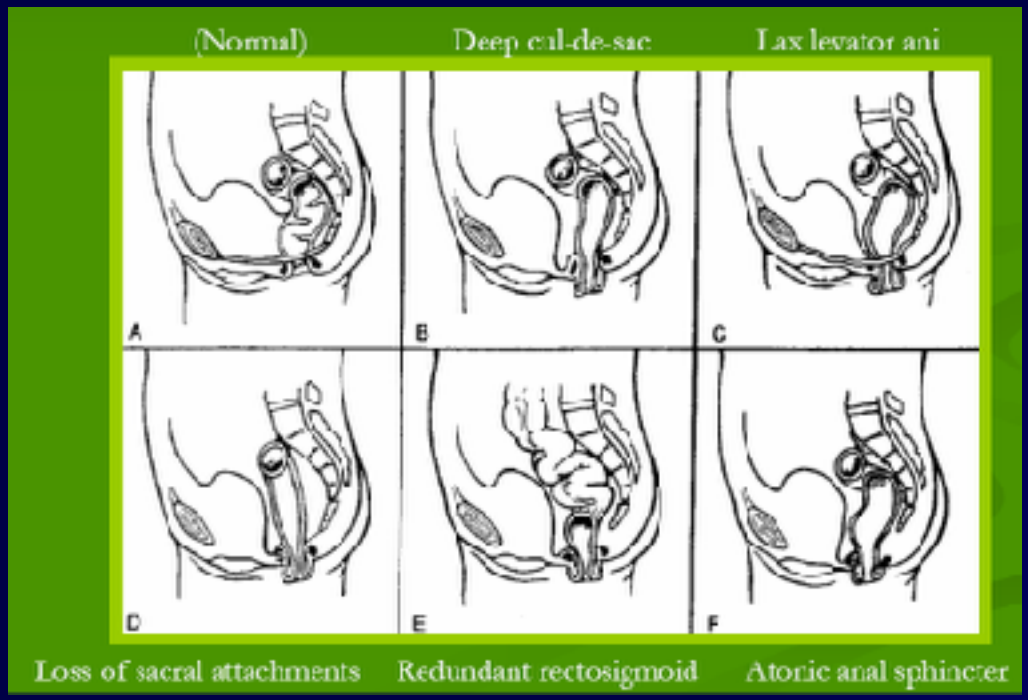
PROLAPSO RECTAL

➢ DEFINICIÓN: Protusión pared completa rectal por ano

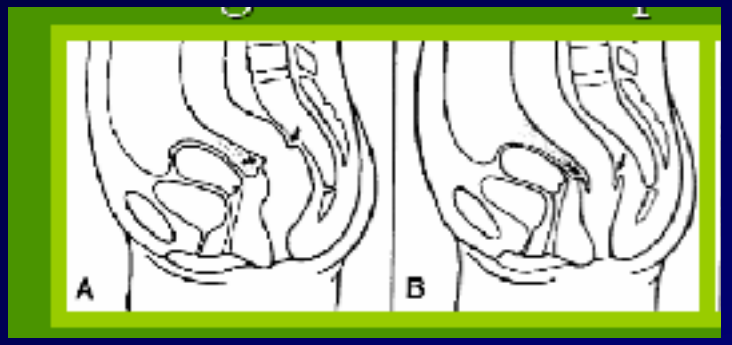
➢ SD.PROLAPSO RECTAL: Prolapso completo exteriorizado o no, prolapso mucoso, intususcepción…

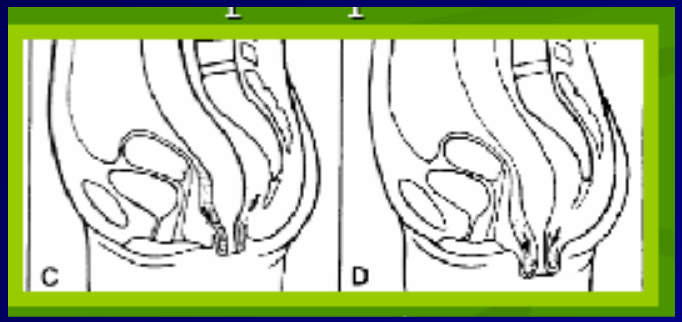
PROLAPSO RECTAL

➢ ORIGEN: Desconocido→ TEORÍAS



Moschcowitz





Broden y Snellman

PROLAPSO RECTAL

CLASIFICACIÓN

ALTEMEIER

- TIPO 1: Prolapso mucoso o falso prolapso
- TIPO 2: Intususcepción rectal con hernia Douglas
- TIPO 3: Hernia Douglas sin intususcepción.

BEAHRS

- Grupo 1: incompleto o parcial (Prolapso mucoso)
- Grupo 2: Completo
  - →Primer grado: interno
  - →Segundo grado: externo Vasalva
  - →Tercer grado: externo

¿Qué hacer?

DX ADECUADO

DX ADECUADO

- Prolapso completo exteriorizado o no, mucoso, intususcepción…
- Incontinencia/estreñimiento
- Celes

Hª CLÍNICA EXPLORACIÓN

Celes

VDF RMN

ENDOSCOPIA

- Descartar otras patologías colon

TPO TRANSITO COLONICO

E.O.

- Longitud y aspecto

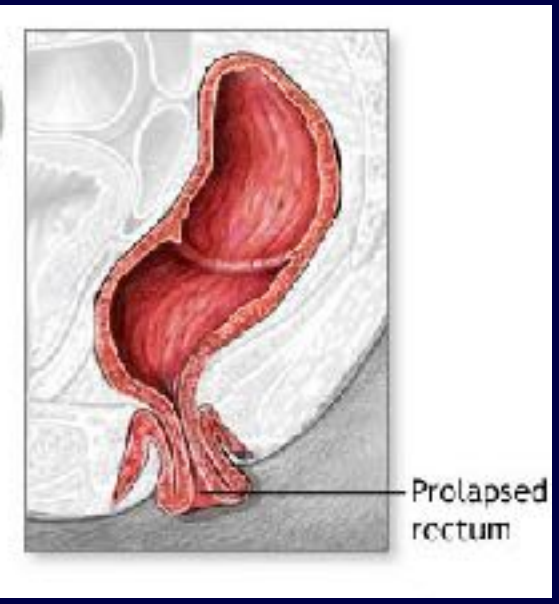
MANOMETRÍA

ECOGRAFÍA RECTAL

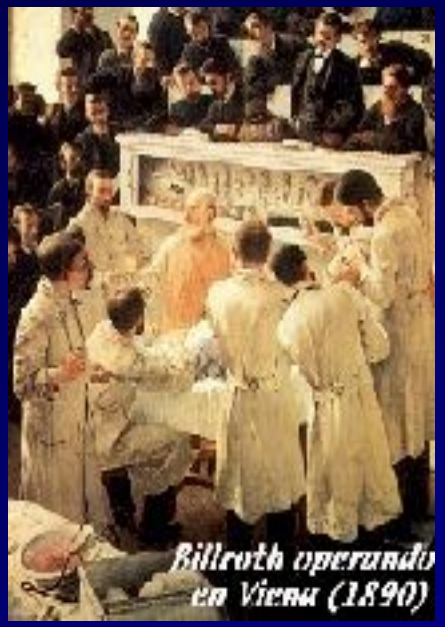
En casos de incontinencia

PROLAPSO RECTAL

OBJETIVOS



- CORREGIR EL PROLAPSO
- RESTAURAR FUNCIÓN RECTAL
- SIN PROVOCAR EFECTOS NOCIVOS

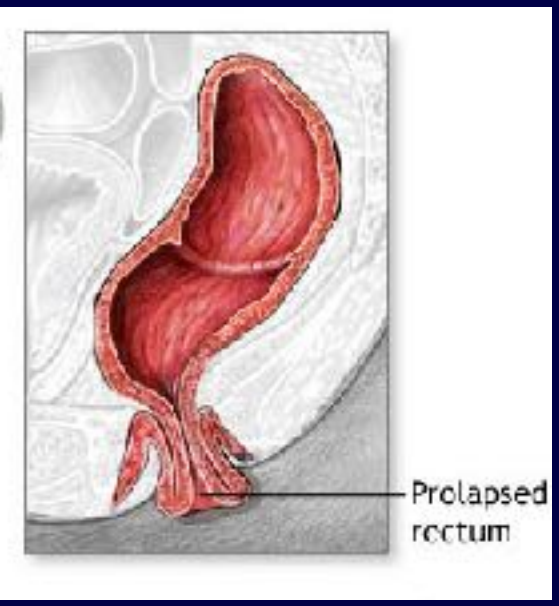


¿Qué hacer?

- TIPO PACIENTE
- TIPO PROLAPSO
- m-m TÉCNICA Q

PROLAPSO RECTAL

TIPO PACIENTE

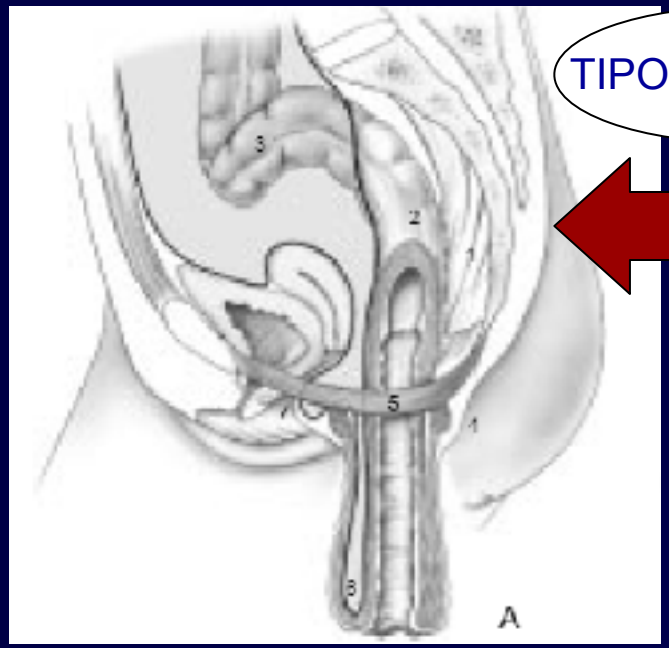


90% 80-90 a

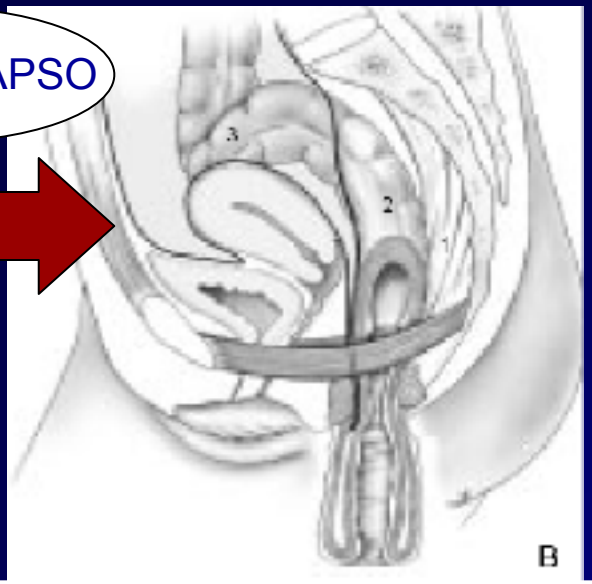
PROLAPSO RECTAL

Prolapso por debilidad

Prolapso por fuerza



TIPO PROLAPSO



Acceso perineal

- Multifactorial
- Mujeres añosas y multíparas.
- Asociado prolapso genital.

Acceso abdominal

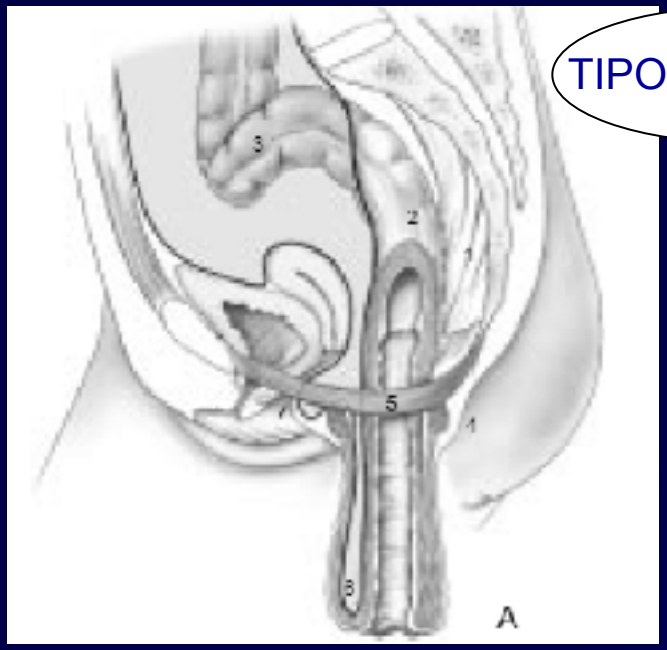
- Oligofactorial
- Adultos jóvenes y nulíparas.
- Periné normal y esfínter continente
- Exceso longitud y movilidad recto

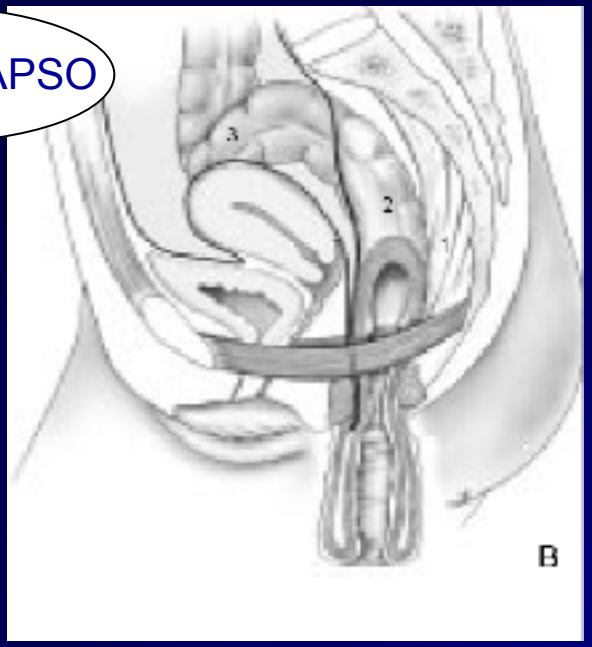
PROLAPSO RECTAL

Incontinencia-Estreñimiento

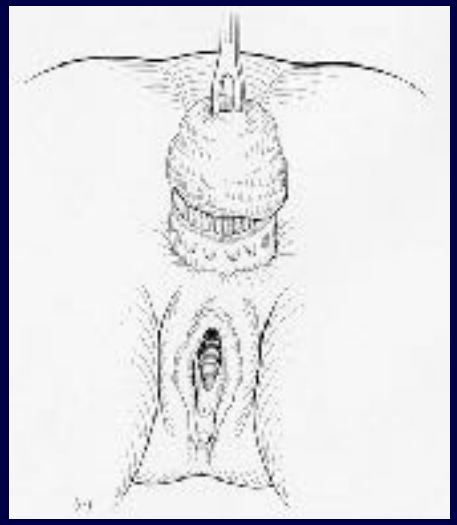
Primario-recidivado

TIPO PROLAPSO

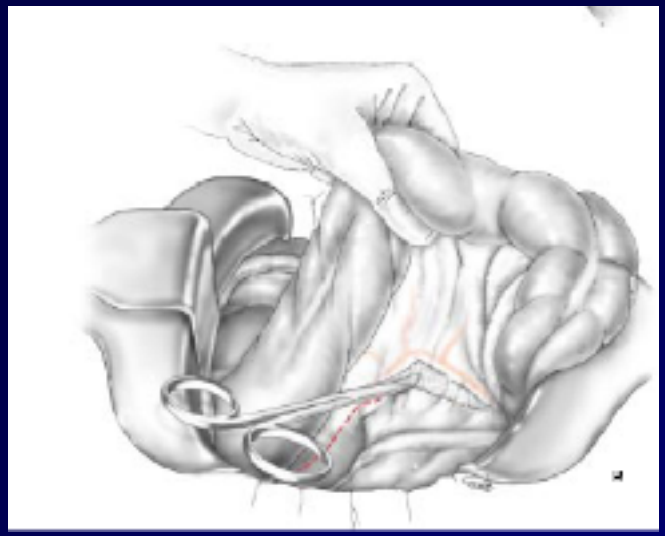




PROLAPSO RECTAL



m-m TÉCNICA Q



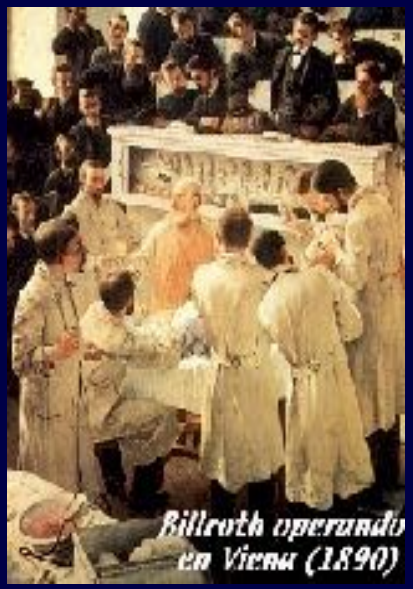
Acceso perineal

Acceso abdominal

- > Recidiva
- > Incontinencia
- Anestesia loco-regional
- < Gravedad

- < Recidiva
- > Estreñimiento (30-80%)
- Anestesia general
- > Gravedad

PROLAPSO RECTAL

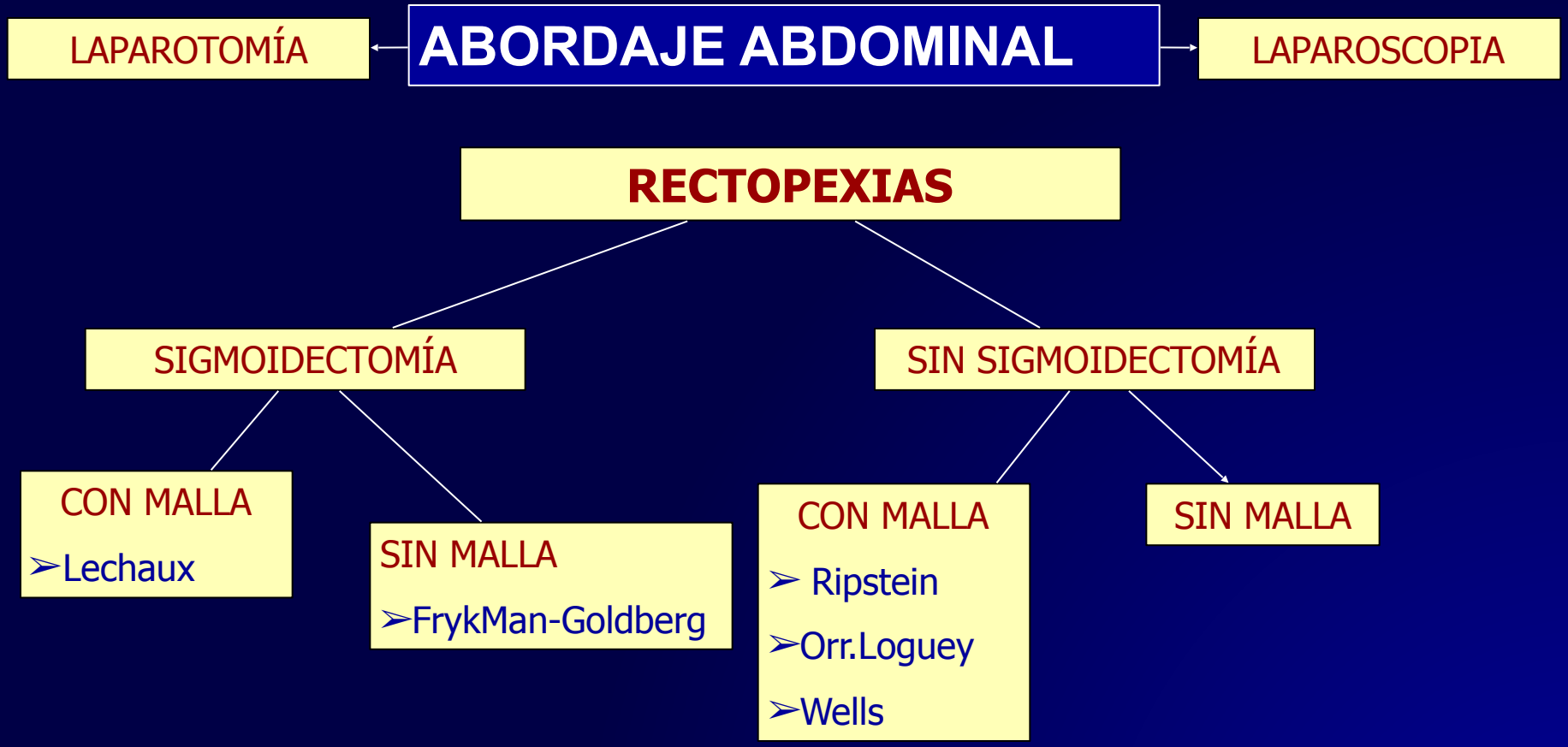


THE COCHRANE COLLABORATION®

"...no hay un tratamiento infalible, único, universal del prolapso rectal, y esto se debe a que hay diversas variedades de prolapso,

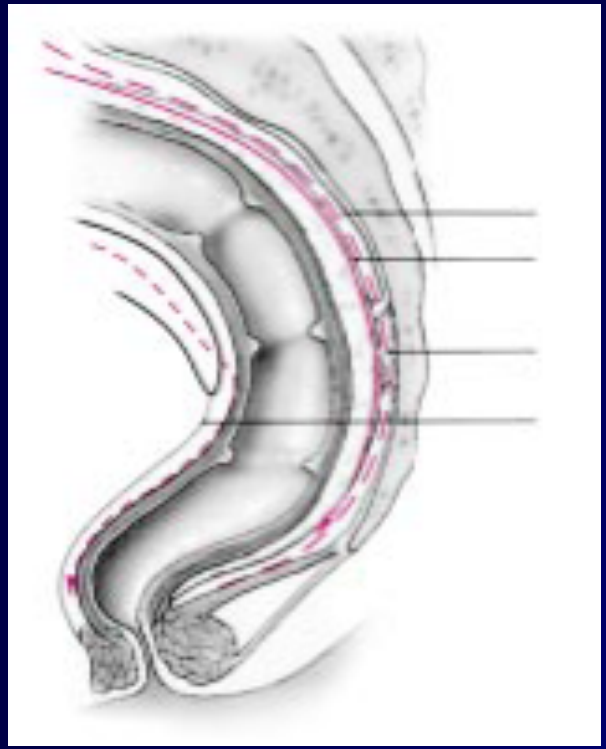
"El pequeño nº de ensayos pertinentes identificados y sus tamaños de muestra pequeños, junto con otras carencias metodológicas limitan establecer prácticas directivas. **Fue imposible identificar o descartar diferencias clínicamente importantes entre operaciones alternativas.** Se necesitan ensayos rigurosos más grandes para mejorar la evidencia para definir el tratamiento quirúrgico óptimo".

PROLAPSO RECTAL



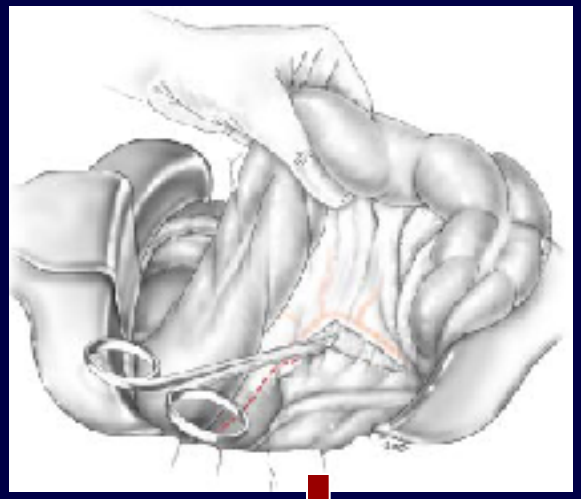
PROLAPSO RECTAL

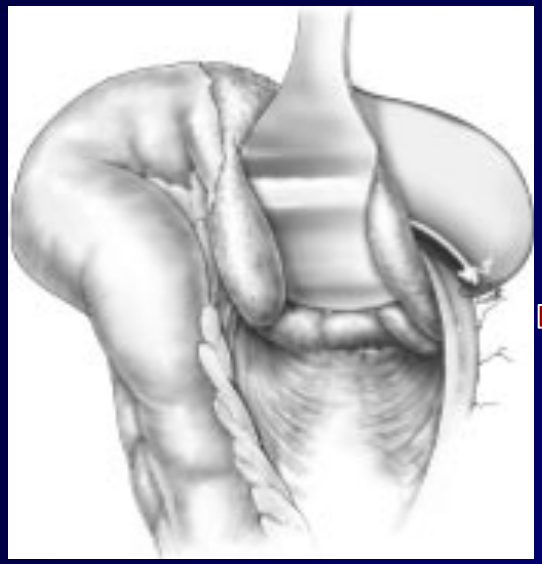
Movilización del recto subperitoneal

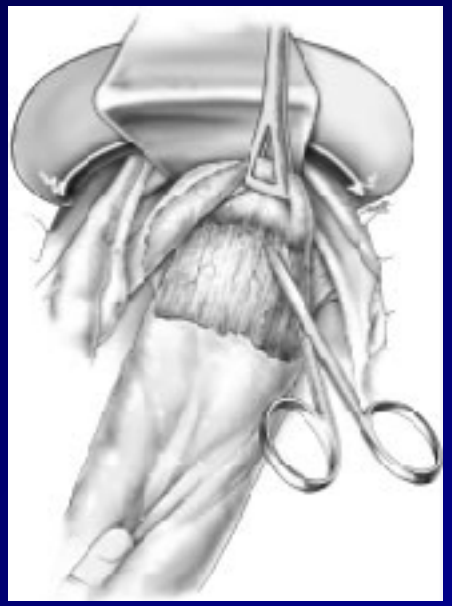


PROLAPSO RECTAL

Movilización del recto subperitoneal

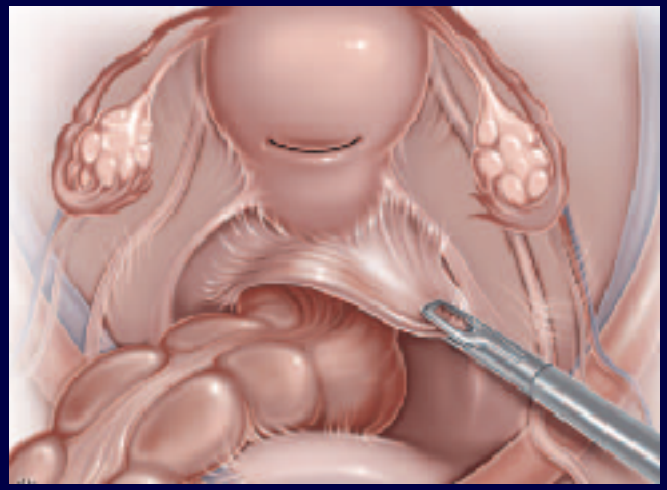


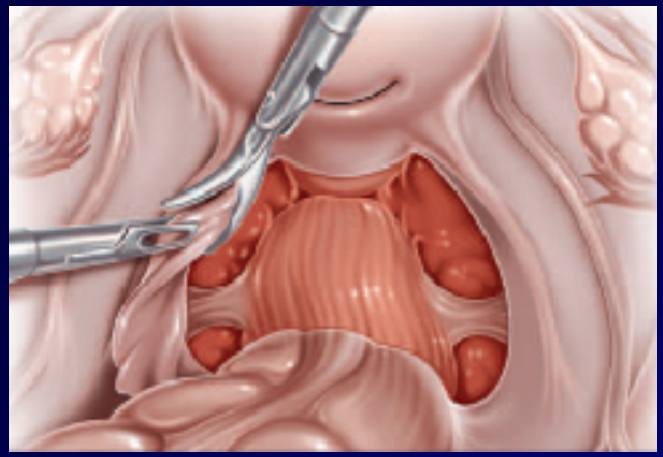


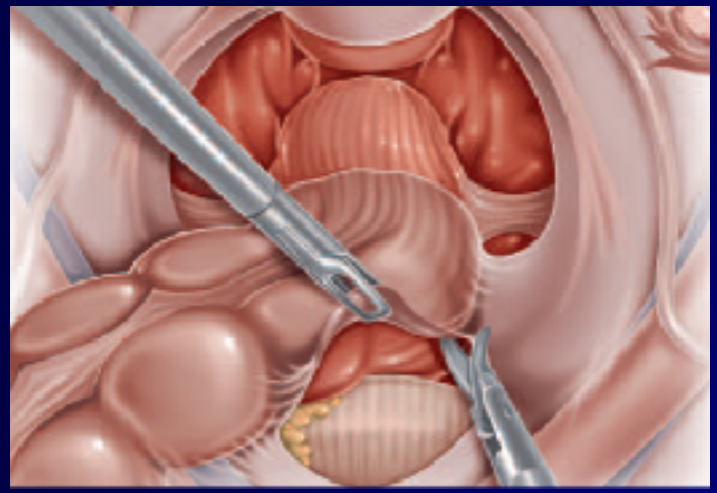


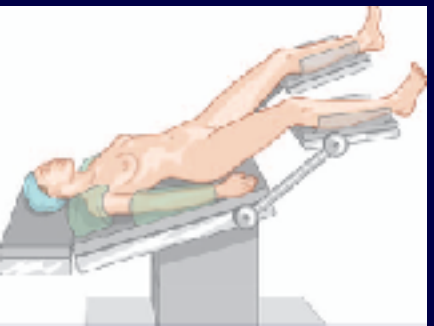
PROLAPSO RECTAL

Movilización del recto subperitoneal









PROLAPSO RECTAL

LAPAROTOMÍA ← **ABORDAJE ABDOMINAL** → LAPAROSCOPIA

RECTOPEXIAS

SIGMOIDECTOMÍA

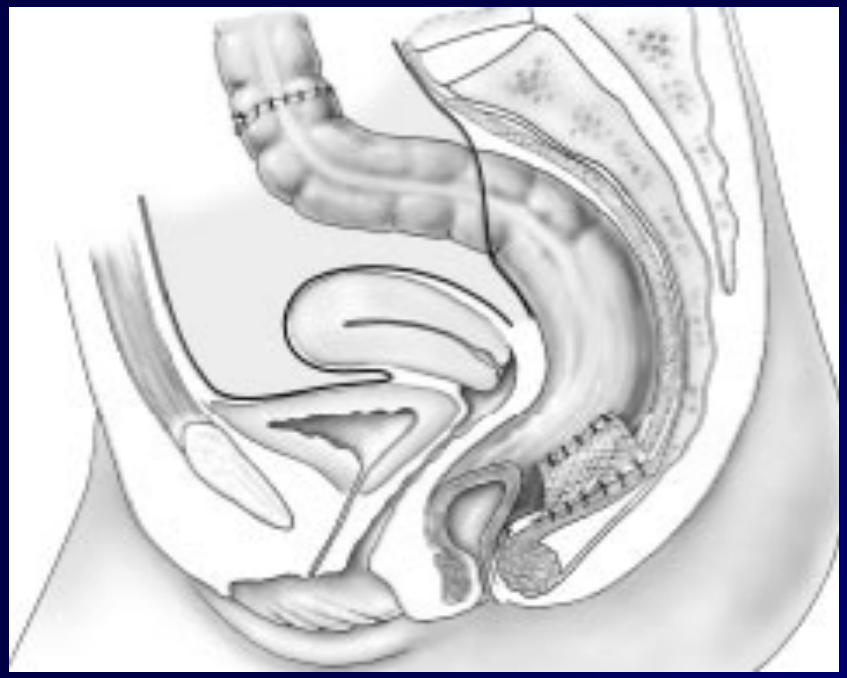
- CON MALLA
  - ➢Lechaux
- SIN MALLA
  - ➢FrykMan-Goldberg

SIN SIGMOIDECTOMÍA

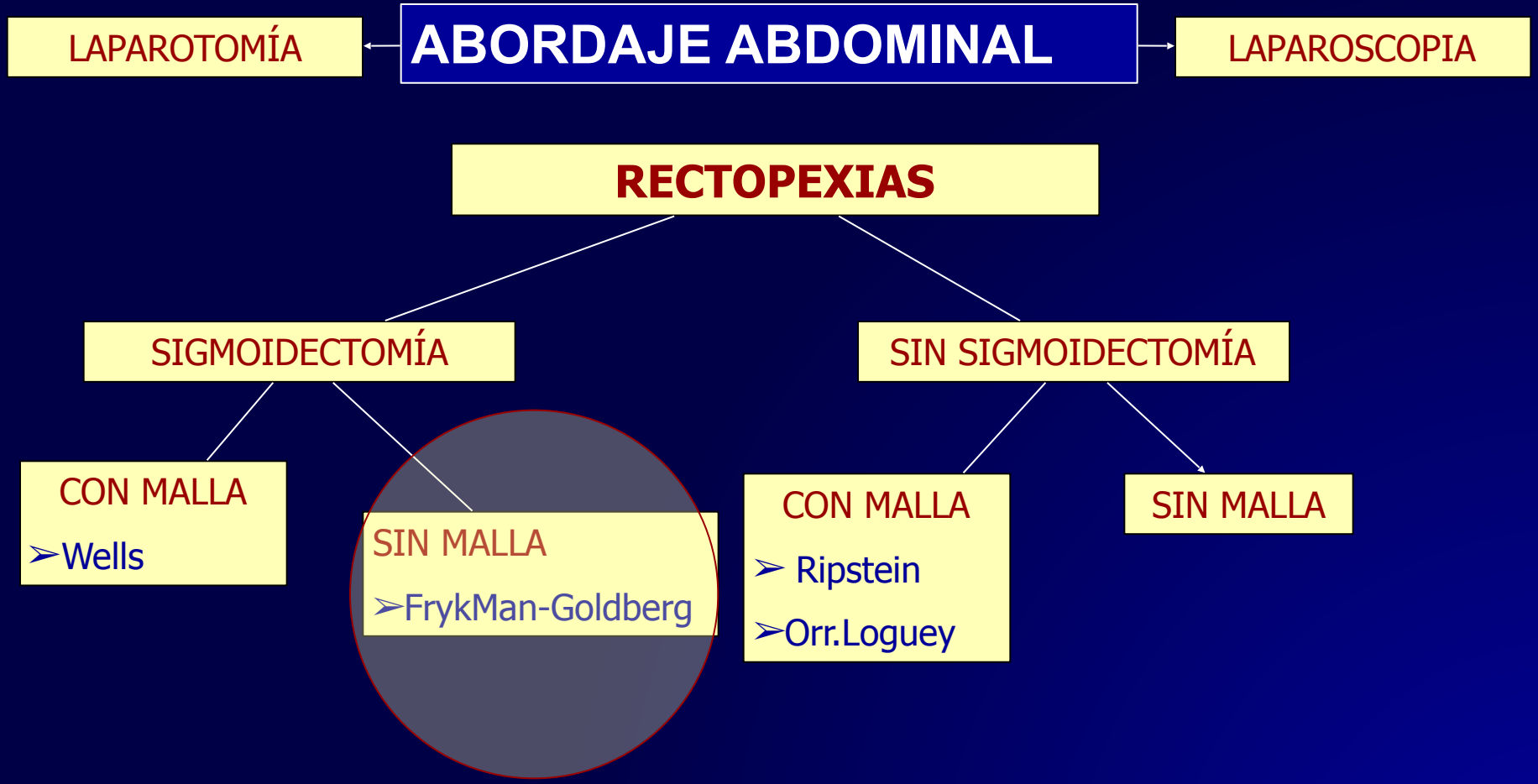
- CON MALLA
  - ➢ Ripstein
  - ➢Orr.Loguey
  - ➢Wells
  - ➢Otras,….
- SIN MALLA

PROLAPSO RECTAL

Rectopexia con malla con sigmoidectomía (Lechaux)

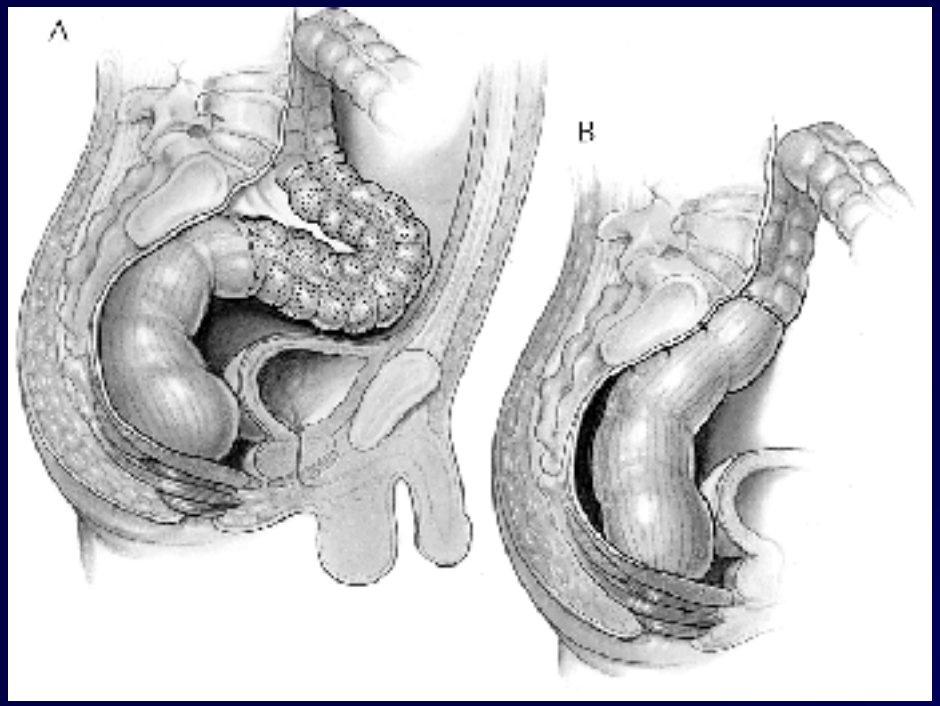


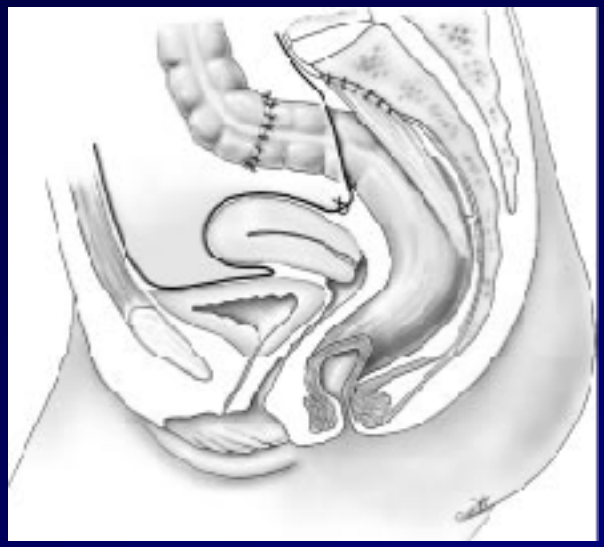
PROLAPSO RECTAL



PROLAPSO RECTAL

Rectopexia sin malla con sigmoidectomía (FrykMan-Goldberg)



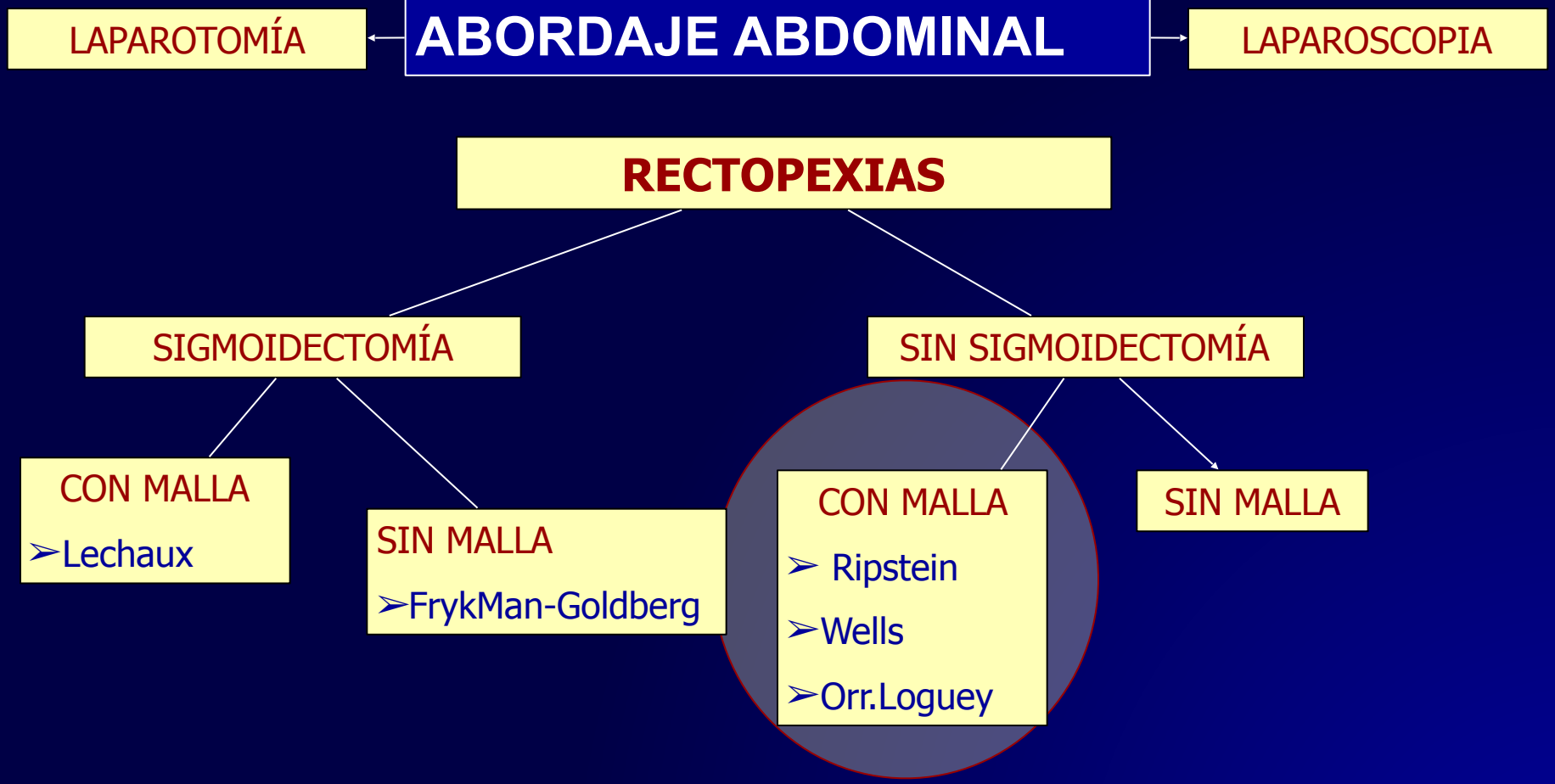


- Recidiva <9%
- Morbilidad <12%
- ELECCIÓN si BEG + ESTREÑIMIENTO

TABLE 12. Resection-rectopexy to treat rectal prolapse

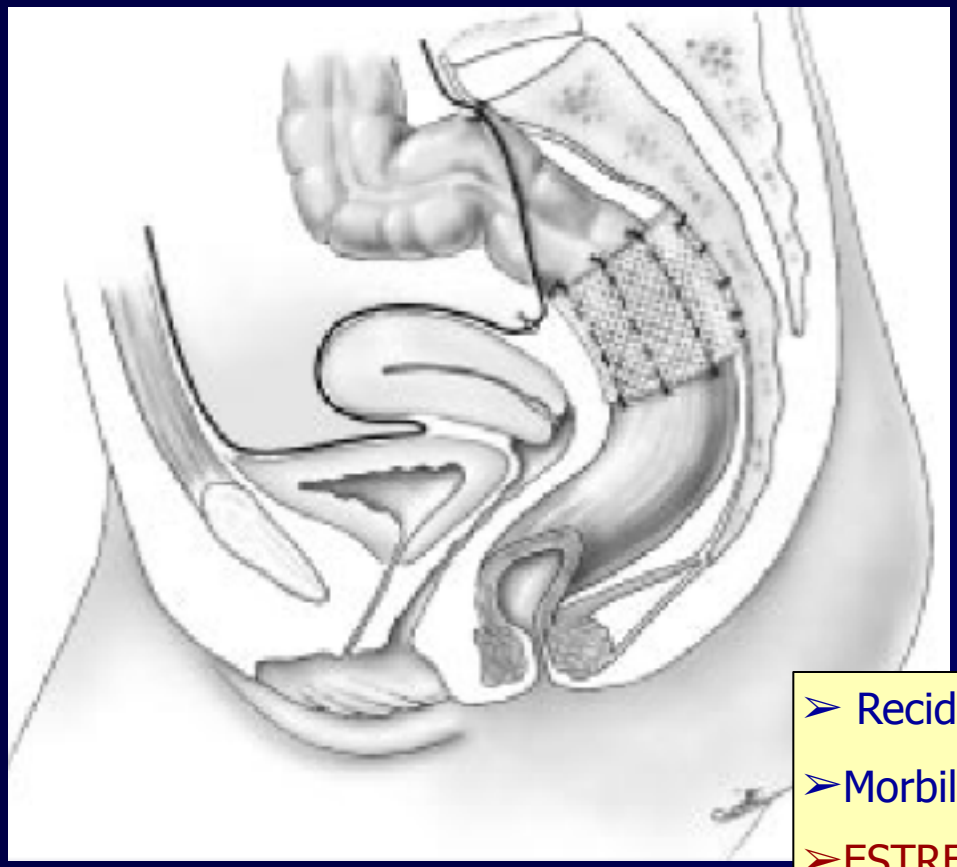
Study	Year	Pts	Age (yr)	M/F	Recurrence
Frykman[328]	1955	8	Avg 44.5 (27–60)	1/7	0
Frykman and Goldberg[330]	1969	67			0
Conyers[331]	1974	9	21–81	1/8	0
Watts[332]	1985	102			2
Husa[333]	1988	48	Mean 53 (21–83)	4/44	4
Madoff[334]	1992	47	Mean 46.8	1/15	3
Huber[335]	1995	37 RP 5 RI	Mean 61.1 (30–78)	1/20	0
Lehur[336]	1996	17 RP 3 RI	Mean 42 (17–69)	6/14	0
Johnson[337]	2007	Lap 15 Open 5	Median 51 (15–79)	5/15	1

PROLAPSO RECTAL



PROLAPSO RECTAL

Rectopexia directa sin sigmoidectomía con prótesis (Ripstein)



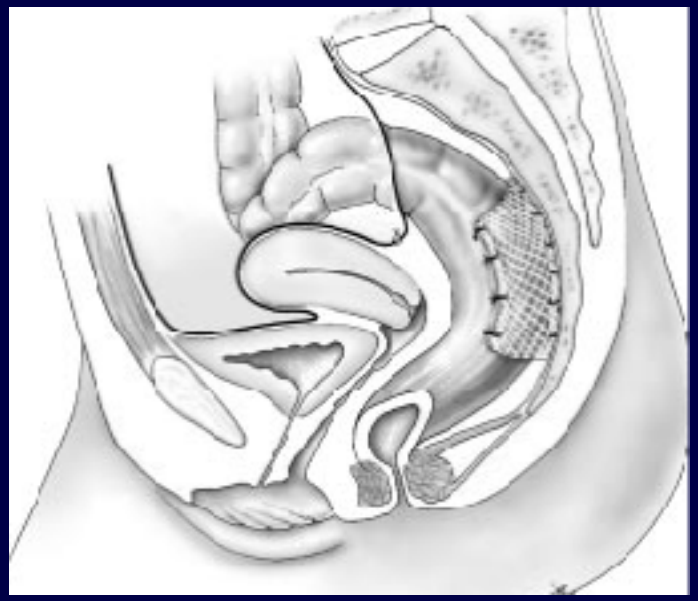
- Recidiva 10%
- Morbilidad 20%
- ESTREÑIMIENTO empeora o aparece 40%

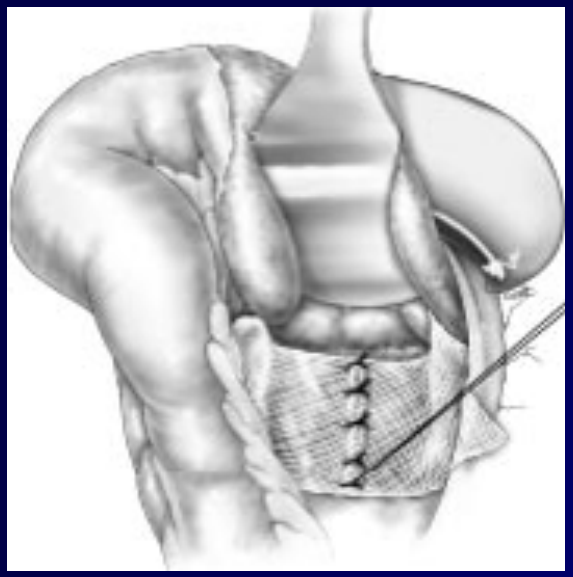
TABLE 11. Rectopexy (Ripstein's procedure) to treat rectal prolapse

Author	Year	Pts	Age	M/F	Recurrence
Ripstein[305]	1952	4	Avg 65	0/4	0
Ripstein and Lanter[306]	1963	45			1
Ripstein[307]	1965	30			0
Gordon and Hoexter[308]	1978	1111			26
Launer[309]	1982	54	Avg 55 (17–87)	7/47	6
Roberts[310]	1988	135		17/118	13
Tjandra[311]	1993	129			
Schultz[312]	1996	24 RP 18 RI	RP mean 59 (18 to 84) RI mean 62 (41–74)	1/41	
Schultz[313]	2000	69 RP 43 RI			1
Bebu[314]	2001	1	78	0/1	
Feldman[315]	2003	1	0/1	Mid 30s	
Karagulle[316]	2006	1	1/0		

PROLAPSO RECTAL

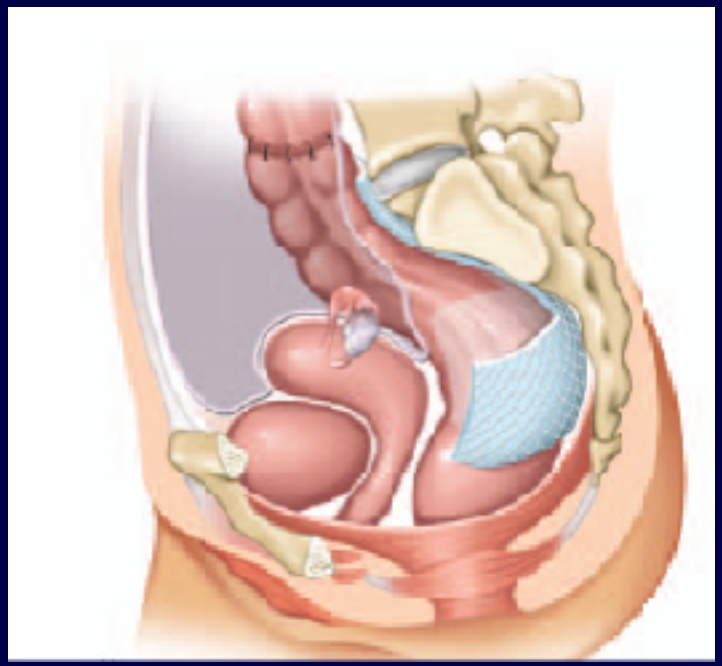
Rectopexia directa sin sigmoidectomía con prótesis (Wells)

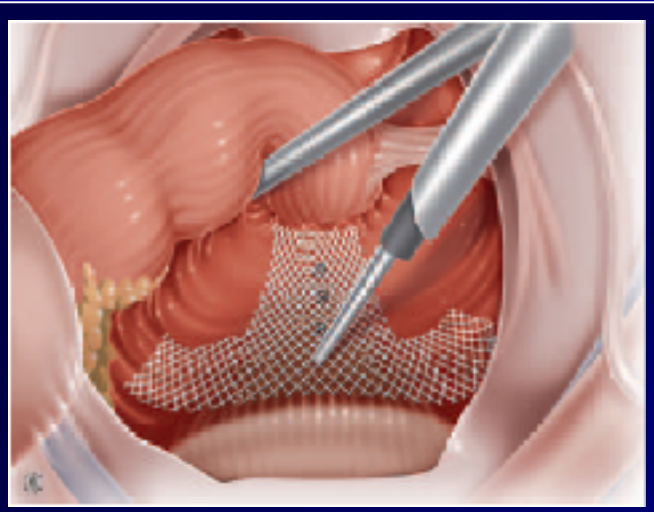


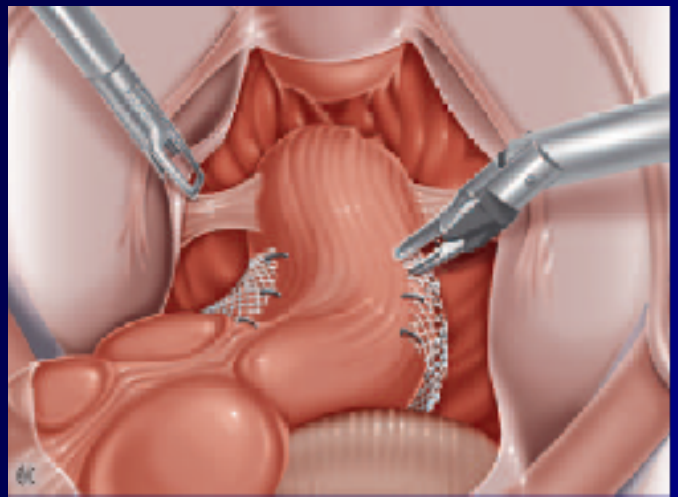


PROLAPSO RECTAL

Rectopexia directa sin sigmoidectomía con prótesis (Wells)







PROLAPSO RECTAL

Wells

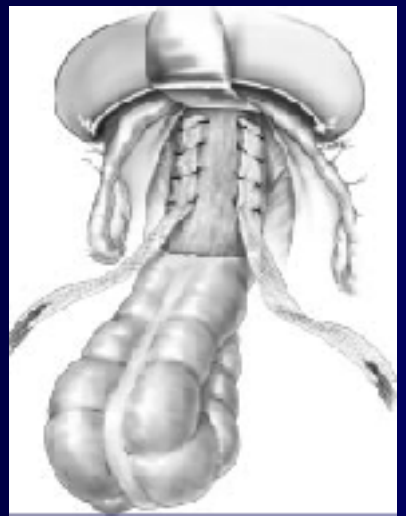
TABLE 10. Rectopexy with polyvinyl alcohol (Ivalon) mesh to treat rectal prolapse (Wells' procedure

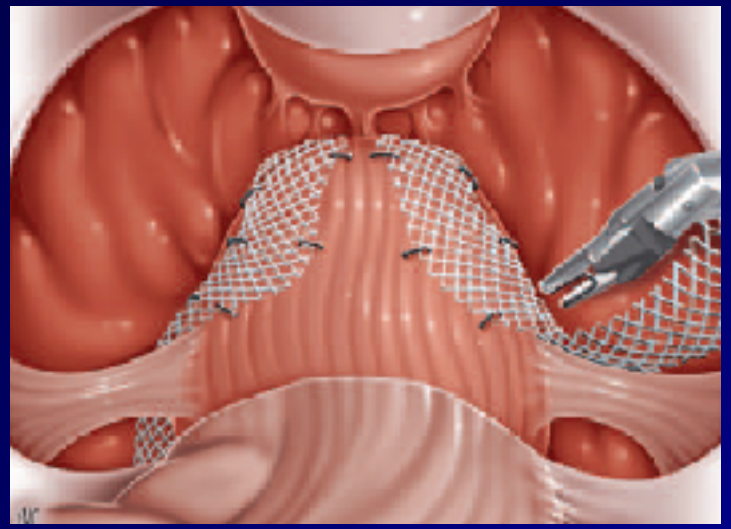
Study	Year	Pts	Age	M/F	Recurrence
Wells[294]	1959	15			
Caine[296]	1966	30		0/30	1
Morgan[295]	1972	150	Mean 65 (24–86)	23/127	3/93 documented cases
Penfold and Hawley[297]	1972	101	21–82		3
Vongsangnak[298]	1985	53	Mean 58.6 (27–92)	3/50	
Ross and Thompson[299]	1989	8		1/7	
Allen-Mersh[300]	1990	57	Mean 64.9 (±15.4)	5/52	

PROLAPSO RECTAL

Rectopexia directa sin sigmoidectomía con prótesis

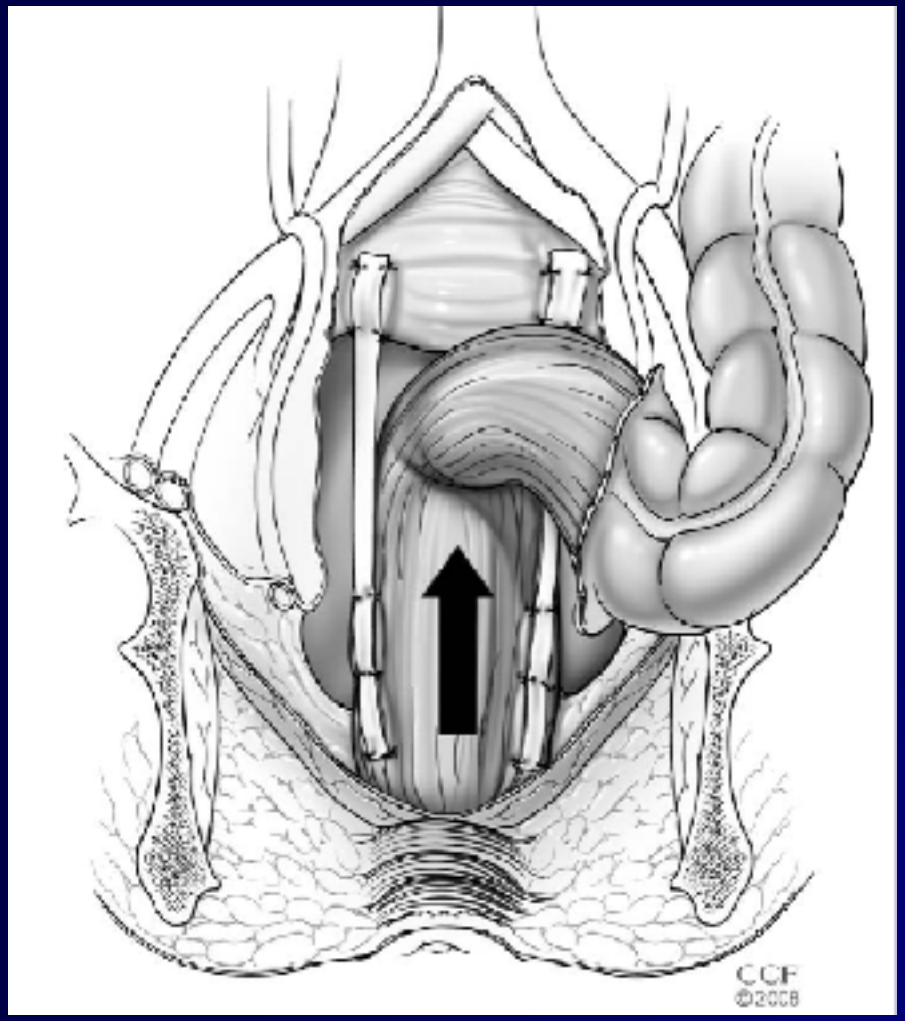
Operación de Orr-Loygue





PROLAPSO RECTAL

Operación de Orr-Loygue



PROLAPSO RECTAL

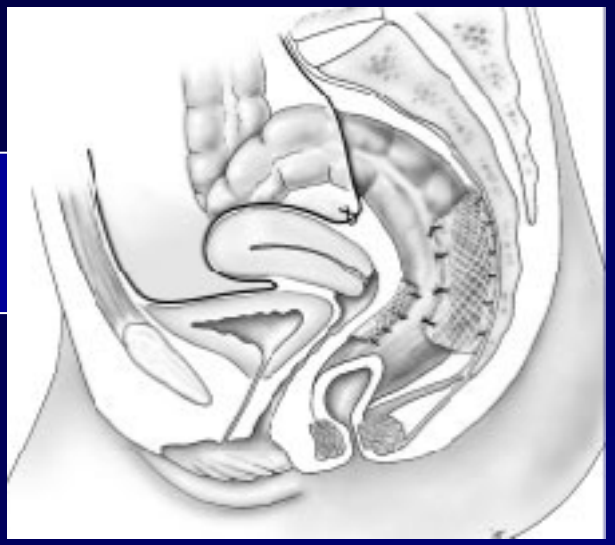
Operación de Orr-Loygue

TABLE 9. The Orr-Loygue operation for the treatment of rectal prolapse

Author	Year	Pts	Age (yr)	M/F	Recurrence
Orr[288]	1947	4	33–68	3/1	0
Loygue[289]	1971	140	Mean 54	31/109	5
Loygue[290]	1984	257	11–90	57/200	13
Douard[291]	2003	31	Mean 65 (32–86)	3/28	0
Marceau[292]	2005	28	Mean 34 (+9)	7/21	2
Portier[293]	2006	73 (51 RP 22 IRP)	Median 61 (22–80)	5/68	3 RP pts

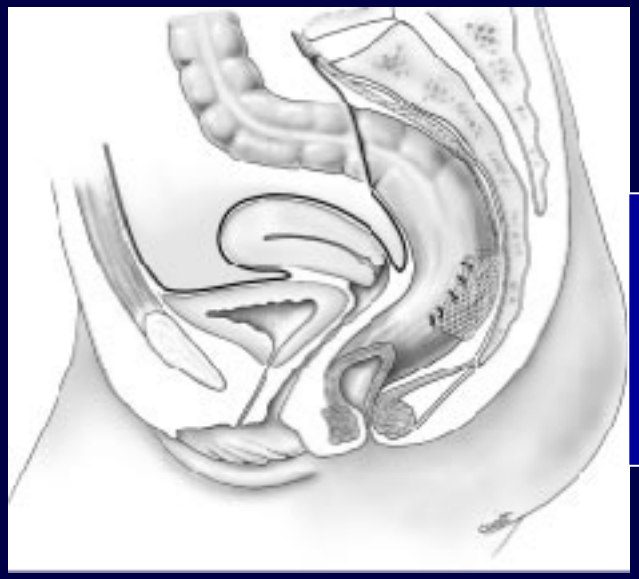
PROLAPSO RECTAL

Rectopexia directa sin sigmoidectomía con prótesis



Operación de Nicholls.

Rectopexia anterior y posterior con prótesis.



Operación de Kuijpers.

Rectopexia con prótesis en T fijada al recto subperitoneal y al promontorio, sin disección anterior.

PROLAPSO RECTAL

ABORDAJE ABDOMINAL

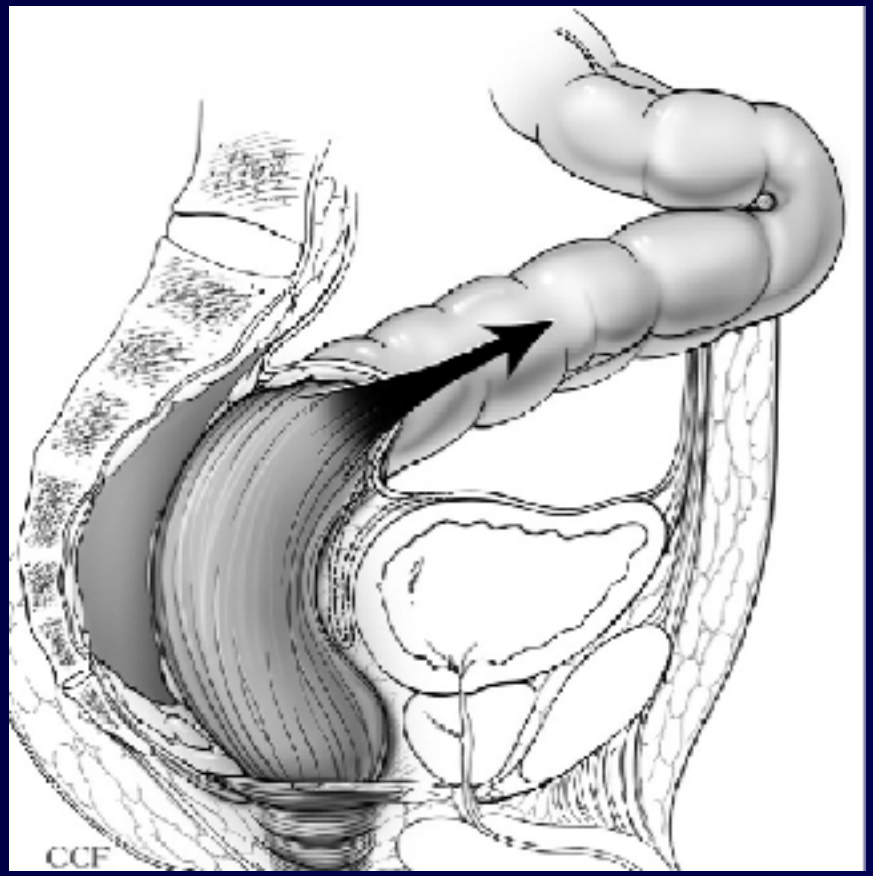
- LAPAROTOMÍA
- LAPAROSCOPIA

RECTOPEXIAS

- SIGMOIDECTOMÍA
  - CON MALLA
    - ➢Lechaux
  - SIN MALLA
    - ➢FrykMan-Goldberg
- SIN SIGMOIDECTOMÍA
  - CON MALLA
    - ➢ Ripstein
    - ➢Orr.Loguey
    - ➢Wells
  - SIN MALLA

PROLAPSO RECTAL

Rectopexia directa sin sigmoidectomía sin prótesis



CLEVELAND CLINIC

- No disección anterior
- Sutura de recto a fascia pre-sacra material irreabsorbible

PROLAPSO RECTAL

Rectopexia directa sin sigmoidectomía sin prótesis

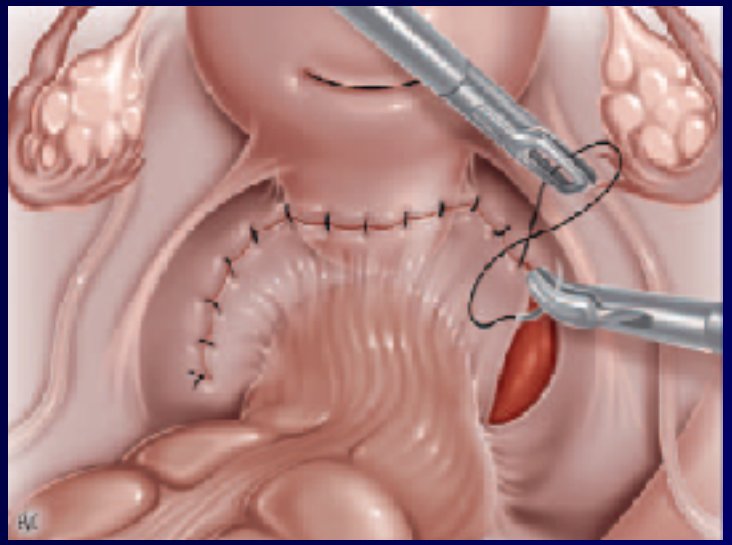
TABLE 8. Sutured rectopexy by open technique to treat rectal prolapse

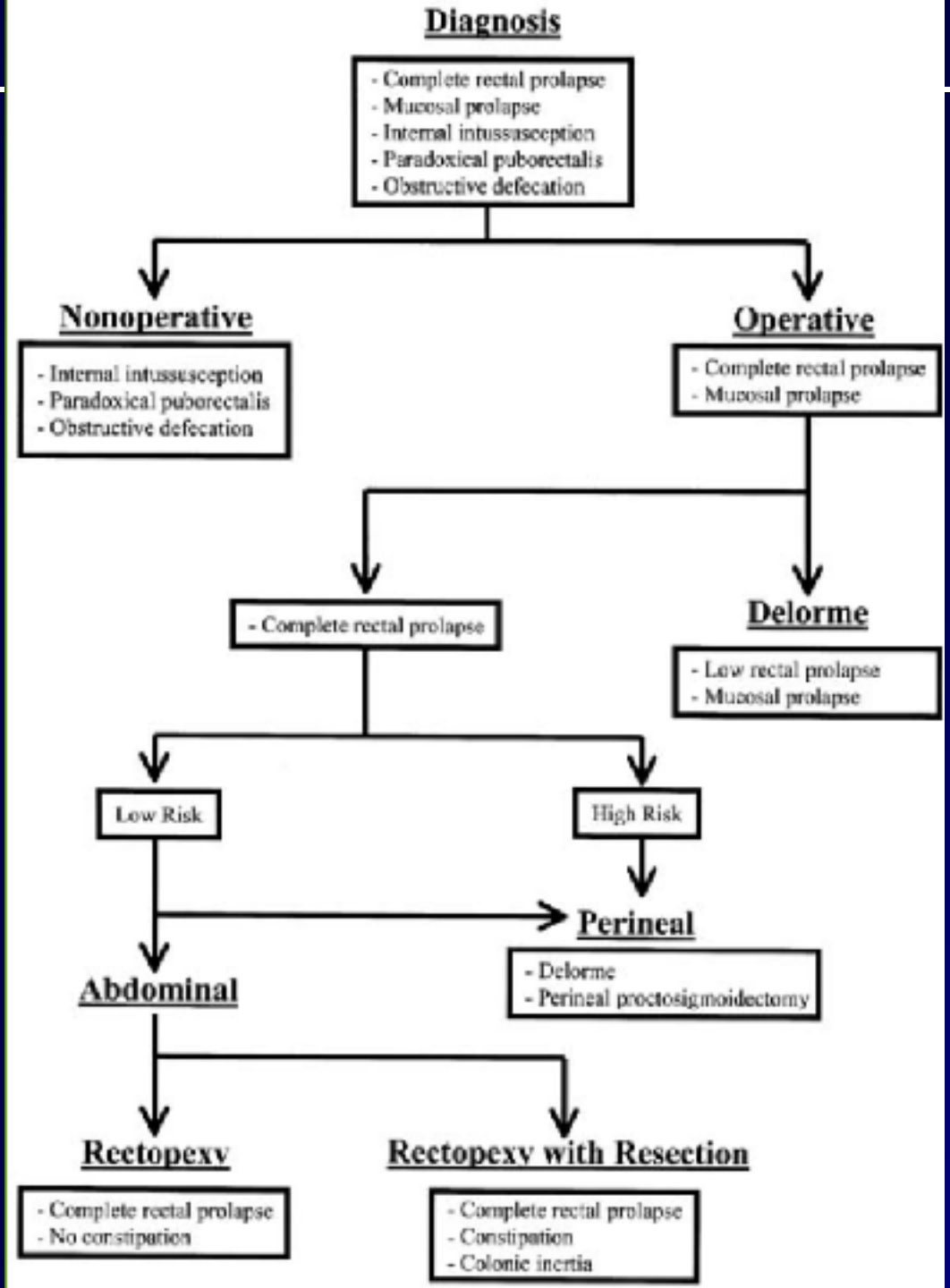
Study	Year	Pts.	Age (yr)	M/F	Recurrence
Newell[280]	1954	1	59	1/0	0
Efron[281]	1977	6	24–74		0
Blatchford[282]	1989	43	Avg 61	5/38	1
Khanna[283]	1996	65	18–64 yr	55/10	0
Brown[284]	2005	12	Median 57 (37–74)	1/11	

Pts, number of patients; M, male; F, female; yr, year(s); mos, months; avg, average.

PROLAPSO RECTAL

Peritonización




Diagnosis
- Complete rectal prolapse
- Mucosal prolapse
- Internal intussaseception
- Paradoxical puborectalis
- Obstructive defecation
Nonoperative
- Internal intussusception
- Paradoxical puborectalis
- Obstructive defecation
Operative
- Complete rectal prolapse
- Mucosal prolapse
- Complete rectal prolapse
Delorme
- Low rectal prolapse
- Mucosal prolapse
Low Risk
High Risk
Perineal
- Delorme
- Perineal proctosigmoidectomy
Abdominal
Rectopexy
- Complete rectal prolapse
- No constipation
Rectopexy with Resection
- Complete rectal prolapse
- Constipation
- Colonic inertia

¿Qué hacer?

TIPO PACIENTE

TIPO PROLAPSO

m-m TÉCNICA Q

PROLAPSO RECTAL

CONCLUSIONES

CONSIDERACIONES PERSONALES

- Prolapso asociado a otros celes: "OTRO TEMA" →Colporrectosacropexia,…
- Rectopexia vía abdominal laparoscópica: TTO ELECCIÓN: si condiciones del paciente lo permiten.
- Malla = no malla (si resección NO MALLA)
- Añadir sigmoidectomía si estreñimiento severo.

- CORREGIR EL PROLAPSO
- RESTAURAR FUNCIÓN RECTAL
- SIN PROVOCAR EFECTOS NOCIVOS