



## Original research

# Intrarectal migration of mesh following Rectopexy: Case series and review of literature



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## HIGHLIGHTS

- We highlight the erosive complications associated with mesh rectopexy.
- We try to define its management protocol based on the review of literature.

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## ABSTRACT

**Introduction:** Mesh rectopexy for complete rectal prolapse is associated with complications such as fecal impaction, constipation and rarely recurrence. Mesh erosion following rectopexy is rare. We report three such cases managed successfully in our unit.

**Presentation of cases:** All three patients presented with constipation. In addition, one patient had sense of incomplete evacuation and another had protrusion of mesh through anal canal with recurrence of rectal prolapse. There was a delayed presentation in one patient at 15 years after initial surgery, while other two presented at 2 years and 5 years following rectopexy. Diagnosis was made by either per rectal examination or sigmoidoscopy. Two patients underwent trans abdominal removal of mesh along with anterior resection of rectum. In one patient, mesh was removed by transanal approach and sutured rectopexy was added to tackle the recurrent prolapse. All patients are symptom free on follow up with no recurrence of prolapse.

**Discussion:** Mesh erosion following rectopexy has multifactorial aetiology with diverse presentation. It is important to recognise this significantly morbid complication as it is amenable to surgical correction. Management depends up on the location of erosion, the severity of mesh protrusion into rectal lumen and the degree of fibrosis around the area of mesh.

**Conclusion:** The management of mesh erosion following rectopexy should be individualized. Although it is complex, acceptable functional outcome and quality of life can be achieved with proper treatment.

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## 1. Introduction

Complete rectal prolapse is the circumferential full thickness descent of rectal wall through the anal orifice. Mesh rectopexy for complete rectal prolapse is an acceptable surgical option with low morbidity and mortality [1]. Due to increasing use of mesh in pelvic

organ prolapse surgery, serious complications such as mesh erosion have been reported. However, there are only few cases of intra rectal mesh migration following mesh rectopexy. Here, we report our experience of three patients of mesh erosion into rectum following mesh rectopexy and also try to define its management protocol based on the review of literature.

## 2. Presentation of cases

### 2.1. Case 1

A 50yr old woman presented with constipation and sense of

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incomplete evacuation since 4 months. She had history of open posterior mesh rectopexy for complete rectal prolapse 15 years back. Her abdominal and per rectal examinations were unremarkable. Sigmoidoscopy revealed a part of the polypropylene mesh projecting into rectum at 10 cm from anal verge with surrounding ulcerated hyperaemic mucosa. Computed tomography(CT) scan of abdomen showed a part of the mesh eroding into rectum with surrounding fat stranding (Fig. 1). Under general anaesthesia, in lithotomy position, infra umbilical laparotomy was performed. After sharp adhesiolysis, only a part of polypropylene mesh was found to be eroding into rectum. As there was limited fibrosis around the region of mesh, anterior resection of the rectum with complete excision of the mesh was performed (Fig. 2). Stapled end to end colorectal anastomosis was made without covering loop ileostomy. She had uneventful recovery and was discharged on 10th postoperative day. At 12 months of follow up she was having an acceptable overall function.

## 2.2. Case 2

A 52yr old woman presented with constipation and hard mass per rectum since 6 months. She underwent open posterior mesh rectopexy for complete rectal prolapse 5 years back. Her abdominal examination was unremarkable except a midline scar. Digital rectal examination revealed recurrence of prolapse and almost whole of the polypropylene mesh protruding out through anal verge along with fecoliths (Fig. 3). In view of recurrence of rectal prolapse with mesh extrusion through the rectum, resection rectopexy with removal of mesh was planned. Infra umbilical mid line laparotomy was performed under general anaesthesia, in lithotomy position. It revealed dense adhesions between sacrum and middle 3rd of rectum. So, only limited mobilization and sutured rectopexy was performed. Near total removal of the mesh was also done by trans anal approach in the same sitting (Fig. 3). Her postoperative course was uneventful and she was discharged on 7th postoperative day. Even after 6 years of follow up, she was doing well without any constipation or recurrence of prolapse.

## 2.3. Case 3

A 56yr old man presented with constipation since 1year. He had history of laparoscopic posterior mesh rectopexy for complete rectal prolapse 2 years back. His abdominal and per rectal examinations were unremarkable. Sigmoidoscopy revealed area of narrowing in the rectum with surrounding hyperaemic mucosa at 12 cm from

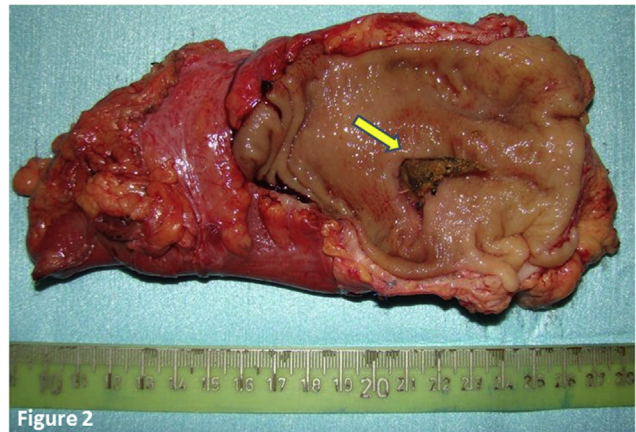


Fig. 2. Specimen of anterior resection showing part of the mesh eroding into rectum (yellow arrow).

anal verge and prolene sutures protruding into lumen. The scope was negotiable with mild resistance. Computed tomography(CT) scan of abdomen showed circumferential wall thickening of rectum with luminal narrowing around the area of mesh. Under general anaesthesia, in lithotomy position, infra umbilical laparotomy was performed. Adhesions were found between the rectum and a proximal ileal loop. A part of the mesh was eroding into small bowel loop and rest of it was adherent to rectum. The rent in proximal ileal loop was closed primarily. In view of limited fibrosis, anterior resection of the rectum with complete excision of the mesh was performed. Hand sewn end to end colorectal anastomosis was done with covering loop ileostomy. His postoperative course was uneventful and he was discharged on 8th postoperative day. Distal loopogram was performed after 3 months which showed no leak or narrowing at anastomotic site. Ileostomy closure was done subsequently. At 5 years of follow up he was having good overall function without any constipation.

## 3. Discussion

Both perineal and abdominal operations are currently practiced for the treatment of complete rectal prolapse. The evidence comparing these surgical procedures is scant and still the best operation for rectal prolapse remains a controversial subject.



Fig. 3. Polypropylene mesh protruding out through anal verge along with recurrence of rectal prolapse (Inset: Specimen of mesh excised by trans anal approach).

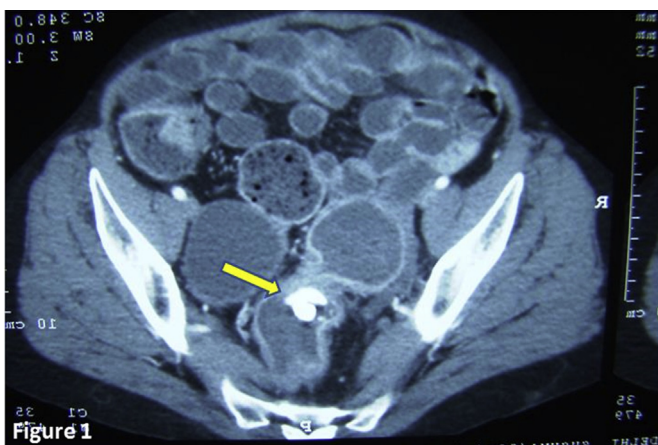


Fig. 1. Axial CT image showing erosion of the mesh into rectum (yellow arrow).

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