Policy Category:
CBA+PA
Who usually applies for funding?
Consultant

Ventral Mesh Rectopexy And Stapled Transanal Rectal Resection (STaRR)

Commissioning decision	The ICB will provide funding for Rectopexy and STaRR for patient who meet the criteria below

Policy statement:

Policy criteria to access treatment – Prior Approval

Surgical treatment will only be provided by the ICB for patients meeting all criteria as set out below:

1. The risks, benefits and side effects of the procedure have been discussed with the patient and the patient wishes to be considered for this treatment.

AND

2. Each patient is to be considered by a Multidisciplinary Pelvic Floor Team, consisting of a gynaecological surgeon, two colorectal surgeons and a pelvic floor physiotherapist and will not be quorate unless a representative from each of these groups is present.

AND

3. The Multidisciplinary Team (MDT) confirms that:
   a) They recommend this treatment for this patient over all alternatives.
   b) The potential benefit outweighs potential harm.
   c) They are satisfied that the necessary capacity and expertise available to handle this intervention is in place in the proposed delivery setting.

AND

4. Conservative management has been tried and has failed. This includes a selection of the following as appropriate for the individual: dietary advice; pelvic floor exercises; osmotic and stimulant laxatives; bulking agents and antispasmodics; glycerine and bisacodyl suppositories and biofeedback and rectal irrigation. The patient will have undergone a proctogram and anorectal physiology teats.

AND

5. The patient has unresolved faecal incontinence or obstructed defecation syndrome.

Revision Surgery – revision or repeat surgeries - Criteria to Access Treatment – INDIVIDUAL FUNDING APPROVAL FUNDING REQUIRED
Revision/repeat surgeries are not routinely commissioned, and an Individual Funding Request must be made to the ICB for consideration prior to any treatment taking place.

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Rationale:

Obstructed defaecation syndrome (ODS) is a complex and multifactorial condition, characterised by an urge to defaecate but an impaired ability to expel the faecal bolus. Symptoms include unsuccessful faecal evacuation attempts, excessive straining, pain, and a sense of incomplete faecal evacuation. ODS is often associated with structural defects in the rectum such as rectocele, internal rectal prolapse and perineal descent. Women, particularly multiparous women, are more likely to present with symptoms of ODS than men. Conservative treatments include diet, biofeedback, laxatives and pelvic floor retraining. In patient's refractory to conservative treatment, and/or if a structural abnormality is present, surgery may be considered including STaRR and Laparoscopic Ventral Mesh Rectopexy. (NICE, 2010)

STaRR procedure:

STaRR procedure is where two circular staplers or a specific stapling device are used to remove the damaged part of the rectum and join the remaining parts back together. (NICE, 2010)

Laparoscopic Ventral Mesh Rectopexy
Laparoscopic Ventral Mesh Rectopexy (LVMR) is an operation which is designed to straighten and attach the rectum back into its normal position within the pelvis. (Glasgow Colorectal Centre)

Plain English Summary:

A rectopexy is an operation in which the rectum (the part of the bowel that is nearest the anus) is put back into its normal position in the body. It is an operation performed for patients with:

- An external rectal prolapse
- An internal prolapse (also known as rectal intussusception)
- A rectocoele (bowel bulging into the vagina)
- Symptoms of obstructive defecation.

Patients with faecal incontinence may also benefit from the procedure.

Evidence base:

This policy has been developed with the aid of the following references:

(Luglio et al., 2017). Ventral mesh rectopexy is used to surgically treat rectal prolapse. Studies have shown high levels of patient satisfaction, good post-operative functional outcomes and lower recurrence rates.

Smart et al., 2013). With regards to the type of mesh used, biological or synthetic, studies show that it should be chosen on a patient-by-patient basis. For example, if the patient is likely to develop a fistula based on their comorbidities (such as Crohn's Disease) then the

higher cost biological mesh should be used, and in uncomplicated cases the less expensive synthetic mesh is justified.

The Dynamed Plus (a point of care tool) summary of Rectal Prolapse (updated April 27 2018) recommends ventral mesh rectopexy (D'Hoore procedure) because it is as effective as other abdominal approaches and has better results with regard to postoperative constipation.

Larger studies also support the post-operative benefits and patient safety (Consten et al), while a systematic review from 2010 shows that support for this surgery is not a recent phenomenon (Samaranayake et al).

NICE guidance is currently being developed and has an expected publication of 20 June 2018 – they have released some documents on their website, including the overview which includes an in-depth look at current studies: https://www.nice.org.uk/guidance/gid-ipg10065/documents/overview

The 2010 NICE guideline and 2016 Clinical Practice guideline both summarise and evaluate the evidence for this procedure.

For further information please contact glicb.ifr@nhs.net

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Policy sign off:

Reviewing Body	**Date of review**
Effective Clinical Commissioning Policy Group	21 June 2018
Integrated Governance and Quality Committee	23 August 2018

Version control:

Version No	**Type of change**	**Date**	**Description of change**
1.0	Initial document	June 2018	New policy
2.0	Review date change	Sept 2019	Review date changed to September 2022
3.0	Review date change	June 2023	Review date changed to June 2026