National Institute for Health and Clinical Excellence

328/2 – Stapled transanal rectal resection for obstructed defaecation syndrome

Consultation Comments table

IPAC date: Thursday 15th April 2010

Com. no.	Consultee name and organisation	Sec. no.	Comments	Response Please respond to all comments
1	Consultee 1 NHS Professional	**1**	I would consider an additional recommendation: Objective investigations to assess the suitability of patients for this procedure should usually include an Evacuation Proctogram. Individuals who also have bowel control problems should be considered for Anorectal physiology. I would suffix colorectal surgeon with the words trained in the procedure This will ensure that only units with access to the approprite investigations are carrying out the surgery and also act as a measure of quality for the Pelvic floor MDT.	Thank you for your comment. The guidance will be changed in section 1.2 to: 'Patient selection and management should involve a multidisciplinary team including a urogynaecologist or urologist and a colorectal surgeon *experienced in this procedure*.'
2	Consultee 2 NHS Professional British Society of Gastroenterology/Specialist Society	**1**	The diagnosis of ODS should be made using a combination of the patients history, clinical examination which will usually exhbit a rectocele and/or rectal intussusception (both in 90% of cases) combined with defaecation proctography or MR proctography.	Thank you for your comment. Section 1.2 states that the procedure 'should be only carried out in units specialising in the investigation and management of pelvic floor disorders.'

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3	Consultee 1 NHS Professional	**2.1**	This does not mention the most commonly considered alternative operation in the UK for ODS symptoms which is a Laparoscopic Ventral mesh Sacrocolporectopey (shortened to LAPVMR).I would suggest that LAPVMR is included in teh choice of other procedures, although you may feel that LAPVMR is in need of its own guidance?!	Thank you for your comment. The guidance will be changed in section 2.1.2 to 'In patients refractory to conservative treatment and/or if a structural abnormality is present, surgery may be considered including stapled transanal prolapsectomy,perineal levatorplasty (STAPL) *and laparoscopic ventral mesh sacrocolporectopexy*'. The consultee has been contacted requesting them to formally notify the procedure to the IP Programme.
4	Consultee 2 NHS Professional British Society of Gastroenterology/Specialist Society	**2.1**	The ODS score can be used to gauge symptom severity and as a tool for audit of treatment outcomes.	The Committee considered this comment but decided not to change the guidance.
5	Consultee 2 NHS Professional Gastroenterology/Specialist Society	**2.2**	It would be sensible that surgeons who undertake this procedure are initially proficient at stapled anopexy using the PPH stapler. Ideally they should attend a course on STARR and then through perceptorship learn to undertake STARR procedures. This process will minimise the risk of complications experienced during the learning curve.	Thank you for your comment. The guidance will be changed in section 1.2 to: 'Patient selection and management should involve a multidisciplinary team including a urogynaecologist or urologist and a colorectal surgeon *experienced in this procedure*.'
6	Consultee 2 NHS Professional Gastroenterology/Specialist Society	**2.3**	The efficacy of STARR is generally only available at 1 year although the Bristol data does give efficacy results at two years. These data relate to the STARR procedure and not to TRANSTARR.	The consultee refers to a study that was identified by an updated literature search and will be added to the main extraction table of the overview (Table 2).

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7	Consultee 2 NHS Professional Gastroenterology/Specialist Society	**2.4**	The largest experience of complications after STARR is based upon the experience in Bristol who have reported continued improvement in postoperative urgency inapproximately 260 patients treated up to 2 years after surgery. Faecal incontinence improves in some patients in STARR but becomes a problem in about 4% of patients after STARR. These patients are usually amenable to subsequent treatment by Sacral Nerve Stimulation.	The consultee refers to a study that was identified by an updated literature search and will be added to the main extraction table of the overview (Table 2).