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The Pelvic Floor Society
Working to Improve Outcomes



The Association of
**Coloproctology of
Great Britain & Ireland**



4th-6th
November 2026

THE PELVIC FLOOR SOCIETY ABSTRACT BOOK

The Pelvic Floor Society Annual Meeting 2026

Abstract book

Mandolay Hotel, Guildford · 5–6 November 2026

Session	When and where	Abstracts
TPFS 2026 – 6 of the best abstracts Oral prize session	Friday 6 November, 10:30 – 11:30 Mandolay Suite	O1 – O6
Video abstracts Shown during the poster session	Friday 6 November, 08:00 – 09:00 Mandolay Suite	V1 – V2
Poster session	Friday 6 November, 08:00 – 09:00 Mandolay Suite	Boards 1 – 23

Prizes will be awarded for the best oral presentation, the best poster and the best video, and for the best abstracts presented by a medical student, a nurse / allied health professional and a trainee.

Contents

TPFS 2026 – 6 of the best abstracts (Friday 10:30 – 11:30)

No.	Title	Presenter
O1	Gluteus Maximus Muscle Transposition for Severe Fecal Incontinence: A Prospective Study of Functional and Electrophysiological Outcomes	Ahmed Moustafa <i>Trainee</i> Maidstone Tunbridge wells hospital
O2	Faecal Incontinence and Working Life	James Barry <i>Trainee</i> University Hospital of North Durham
O3	Quality of online information for patients with obstructed defaecation	Sabina Wallace-King <i>Trainee</i> University Hospital North Durham
O4	Prevalence of Disordered Eating and Eating Disorders in Faecal Incontinence and Constipation: A Systematic review and Meta-analysis	Zirong Song <i>Medical student</i> Imperial College London
O5	Surgical Choice and Regret in Older Adults: A Comparison of Delorme's Procedure and Ventral Mesh Rectopexy for Full-thickness Rectal Prolapse Repair	Wai Miu Emma Liu <i>Medical student</i> King's College London
O6	Assessment of segmental anal canal distensibility in incontinent patients with and without recto-anal rectal intussusception using EndoFLIP	Matthew Davenport <i>Trainee</i> Manchester University NHS Foundation Trust

Video abstracts (Friday 08:00 – 09:00)

No.	Title	Presenter
V1	Combined Robotic Ventral Mesh Rectopexy and Laparoscopic Sacrocolpopexy for Multicompartment Pelvic Organ Prolapse	Sumathi Nadikuditi <i>Trainee</i> Ninewells Hospital
V2	Sphincter Preserving Proctectomy for Recurrent Rectal Prolapse	Mamata Battili <i>Trainee</i> NHS Tayside

Posters (Friday 08:00 – 09:00)

No.	Title	Presenter
P1	Impact of postpartum pelvic floor dysfunction: a qualitative systematic review and metaggregation	Elizabeth Doxford-Hook <i>Trainee</i> University of Leeds
P2	A systematic review investigating the association between mode of birth and long-term pelvic floor dysfunction.	Miriam Wassell <i>Medical student</i> University of Nottingham
P3	Patient Satisfaction, Quality of Life and Continence Status Following Surgical Treatment of Pelvic Floor Damage Using the Modified Preanal Repair Method: A Retrospective Follow-up Survey	Daniel Weber <i>Postgraduate student</i> University Medical Center Schleswig-Holstein, Kiel, Germany
P4	Prevalence of Gastrointestinal Symptoms in Endometriosis: A Systematic Review	Graziele De Araujo Perini <i>Medical student</i> Imperial College School of Medicine
P5	Gut Microbiota Dysbiosis in Irritable Bowel Syndrome and its Relationship with Anxiety and Depression: A Narrative Review	Rudrani De <i>Medical student</i> University of Buckingham
P6	Changing goalposts: the implications of the new Rome V criteria for dyssynergia defecation for pelvic floor services	Charlotte Keyse <i>Postgraduate student</i> Manchester University NHS Foundation Trust



No.	Title	Presenter
P7	Impact of pre-procedure telephone assessment on attendance, compliance and completion of insourced urodynamics clinics versus NHS urodynamics clinics: A service evaluation.	Rebecca Hall <i>Nurse / AHP</i> Manchester University NHS Foundation Trust
P8	Faecal Incontinence: Is it Right to ROME?	James Barry <i>Trainee</i> University Hospital of North Durham
P9	Faecal Incontinence and its Risk Factors: An Update	James Barry <i>Trainee</i> University Hospital of North Durham
P10	A Single-Centre, 25-Year Experience in the Surgical Management of Constipation	James Barry <i>Trainee</i> University Hospital of North Durham
P11	Sacral Neuromodulation is an effective treatment for Bowel Dysfunction in adult patients with childhood history of Imperforate Anus	Kelly Stackhouse <i>Nurse / AHP</i> Sandwell and West Birmingham NHS Trust
P12	Bridging the Gap: A Multicentre Evaluation of the AF500X	Claire Sampson <i>Nurse / AHP</i> North West Anglia NHS Foundation Trust
P13	Real-World Pilot Study Assessing Intermittent Colonic Exoperistalsis (ICE) Treatment with a Novel Medical Device in Adults with Chronic Constipation	Tatenda Marunda <i>Nurse / AHP</i> St Mark's Hospital, The National Bowel Hospital, London
P14	Understanding Regret After Delorme's Procedure: Postoperative Outcomes, Predictors, and Patient-Reported Outcomes	Wai Miu Emma Liu <i>Medical student</i> King's College London
P15	"It Changed My Life, or It Was Too Much": A Patient Centred Account of the Rectal Irrigation Pathway	Wai Miu Emma Liu <i>Medical student</i> King's College London
P16	Barriers to Rectal Irrigation: A Patient-Centred Qualitative Study of Practical, Emotional and Social Challenges	Tanzeela Gala <i>Trainee</i> Guy's and St Thomas' NHS Foundation Trust
P17	"Real World Irrigation": How Patients Share Rectal Irrigation Experiences on TikTok	Tanzeela Gala <i>Trainee</i> Guy's and St Thomas' NHS Foundation Trust
P18	Differential Predictors of Regret in Younger vs Older Adults Undergoing Ventral Mesh Rectopexy: a 10-year Retrospective Cohort Analysis	Tanzeela Gala <i>Trainee</i> Guy's and St Thomas' NHS Foundation Trust
P19	Recurrence and complications after ventral mesh rectopexy: a single-centre retrospective cohort study	Sophia Moschkau <i>Trainee</i> Northumbria Healthcare NHS Foundation Trust
P20	Suture versus Taker Rectopexy for Young Male Rectal Prolapse: A Retrospective Analysis of Recurrence and Perioperative Outcomes	Ammar Aleter <i>Trainee</i> Hamad Medical Corporation
P21	Impact of Levatorplasty on Recurrence Following Altemeier's and Delorme's Procedures: Systematic Review and Meta-Analysis	Praveen Sekaran <i>Trainee</i> Basildon University Hospital, Mid and South Essex NHS Trust
P22	Does the NHS Bristol Royal Infirmary Rectal Prolapse service meet the NHS England 18-Week RTT Standard? A Baseline Audit	William Strachan <i>Trainee</i> Bristol Royal Infirmary, Bristol
P23	Robot-assisted apical pelvic floor reconstruction with selective mesh use: early outcomes from a UK tertiary centre	Hara Koukouli <i>Trainee</i> University College London Hospitals NHS Foundation Trust



TPFS 2026 – 6 of the best abstracts

Oral prize session · Friday 6 November, 10:30 – 11:30 · Mandolay Suite

Gluteus Maximus Muscle Transposition for Severe Fecal Incontinence: A Prospective Study of Functional and Electrophysiological Outcomes

Presenting author: Ahmed Moustafa (Surgical / medical trainee)

Institution: Maidstone Tunbridge wells hospital

Co-authors: Ahmed Farag Ahmed Farag¹, Mohamed Raslan¹, Mohamed Alatrash²

¹Cairo University

²Maidstone Tunbridge wells hospital

Background

Fecal incontinence is a debilitating condition with significant physical and psychological consequences, often severely impairing quality of life. Surgical management remains challenging in patients with extensive sphincter damage who are unsuitable for conventional repair. Gluteus maximus muscle transposition has emerged as a promising reconstructive option for neosphincter creation.

Aim

To evaluate the functional, manometric, and electrophysiological outcomes of gluteus maximus muscle transposition in patients with severe fecal incontinence.

Methods

This prospective study included 22 patients with refractory fecal incontinence treated between August 2018 and October 2020. All patients underwent gluteus maximus transposition for neosphincter reconstruction. Preoperative and postoperative assessments included Wexner score, Farag's grading system, anorectal manometry, defecography, and electromyography (EMG). Patients were followed for six months.

Results

Significant improvement in continence was observed postoperatively. The mean Wexner score decreased from 16.2 to 7.1 ($p = 0.005$), while Farag's grade improved from 4.5 to 2.2 ($p = 0.004$). Manometric analysis showed significant increases in maximum resting pressure (22.3 to 45.8 mmHg, $p < 0.001$) and maximum squeeze pressure (54.4 to 91.6 mmHg, $p = 0.002$). Defecographic findings demonstrated increased anal canal length and reduced canal diameter. EMG revealed preserved or improved muscle activity in the majority of patients.

Conclusion

Gluteus maximus muscle transposition is an effective surgical option for patients with severe fecal incontinence who are not candidates for primary sphincter repair. It provides significant functional and physiological improvement, although postoperative wound complications remain a concern.

Faecal Incontinence and Working Life

Presenting author: James Barry (Surgical / medical trainee)

Institution: University Hospital of North Durham

Co-authors: Kingston, A¹ Lamb, J¹ Liddle, T¹ Yiannakou, Y.² Noblett, S²

¹Newcastle University, Newcastle Upon Tyne

²University Hospital of North Durham, Durham

Background

Faecal incontinence (FI) affects approximately 8% of community-dwelling adults and has far-reaching consequences for daily life. Employment is fundamental to financial security, personal and social well-being, and the wider economy. This study evaluated the impact of FI on employment and work productivity.

Methods

A cross-sectional, FI-focused questionnaire was distributed through two national consent-for-contact research registries (Contact ME-IBS and Research+ME). Data was collected on FI symptoms, disease severity, employment, work productivity and psychosocial health.

Results

Of 3,384 respondents, 1,209 (35.9%) reported FI, of whom 760 were employed. Overall, 313 (41%) could work from home, with 72 (23%) reporting this was essential for symptom management. Participants reported a mean of 11.3 working days lost annually because of FI.

Increasing Vaizey severity score independently predicted greater working hours lost ($B=1.32$, 95% CI 0.85–1.80; $p<0.001$) and greater work productivity impairment ($B=0.28$, 95% CI 0.22–0.34; $p<0.001$). Younger age, mental health conditions and poorer EQ-5D health scores were also independently associated with greater absenteeism (all $p<0.001$). Work productivity differed by FI subtype ($H=14.89$, $p<0.001$), with mixed FI demonstrating the greatest productivity impairment ($p<0.001$).

Conclusions

FI has a substantial impact on employment through reduced work productivity and absenteeism with significant implication to the individual. This is an important but often overlooked indirect measure of disease economic burden. Younger individuals, those with mental health conditions and mixed FI appear particularly vulnerable. These findings should inform symptom counselling, workplace support and healthcare policy when evaluating the overall burden of FI.

Quality of online information for patients with obstructed defaecation

Presenting author: Sabina Wallace-King (Surgical / medical trainee)

Institution: University Hospital North Durham

Co-authors: Cristina Frattini¹

¹University Hospital North Durham

Introduction

Obstructed defaecation is commonly attributed to paradoxical pelvic floor contraction (dyssynergic defaecation), for which first-line management involves pelvic floor relaxation, biofeedback, and behavioural modification. Patients increasingly seek health information online, yet the accuracy of advice regarding obstructed defaecation remains unexamined. The aim for this project was therefore to assess the quality and completeness of website content available to patients.

Methods

Five Google searches were undertaken using the following search terms: "difficulty emptying bowels pelvic floor," "obstructed defecation treatment," "dyssynergic defecation treatment," "pelvic floor dysfunction constipation," and "pelvic floor exercises constipation." The first ten results per search were included, excluding password-protected sites and pure service advertisements. Each site was assessed against criteria spanning pathophysiology (e.g., mention of dyssynergia, paradoxical contraction), treatment content (relaxation vs. strengthening instructions, biofeedback), and behavioural advice (toileting position, avoiding straining, breathing). Sites were classified "clinically complete" if they provided comprehensive, pathophysiology-appropriate guidance.

Results

50 websites were included. Only 16% (8/50) were deemed clinically complete. 84% (42/50) contained potentially misleading or incomplete advice. Strengthening was mentioned by 44% (22/50) and relaxation by 48% (24/50), yet specific instructions for pelvic floor relaxation were provided by only 10% (5/50) versus 14% (7/50) for strengthening. Dyssynergia was defined by 48% (24/50), paradoxical contraction was mentioned by 30% (15/50). Biofeedback and pelvic floor physiotherapy were mentioned by 72% (36/50) and 60% (30/50) respectively.

Conclusion

The majority of patient-facing websites provide incomplete or potentially inappropriate advice for obstructed defaecation, with strengthening emphasised over relaxation. This may mislead patients and delay evidence-based care.

Prevalence of Disordered Eating and Eating Disorders in Faecal Incontinence and Constipation: A Systematic review and Meta-analysis

Presenting author: Zirong Song (Undergraduate medical student)

Institution: Imperial College London

Co-authors: Zirong Song¹, Amal Ahmed⁴ MBBS, BSc Hons, Grazielle De Araujo Perini¹, Rachel Fernandes¹, Symriti Kaur-Paneser¹, Emma V Carrington^{2,3} PhD, FRCS

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Constipation and faecal incontinence (FI) are stigmatised disorders that impair quality of life. Eating pathologies, encompassing disordered eating behaviours, such as dietary restrictions, and eating disorders, have been anecdotally described in these patients and often perceived as coping strategies despite their potential to exacerbate bowel dysfunction and complicate management. Establishing their prevalence is important to identify at-risk individuals and behaviours as potential targets for tailored dietary support.

This study aimed to determine the prevalence of eating pathology in patients with constipation and FI. MEDLINE, Embase, PsycINFO, CINAHL and PubMed were systematically searched from January 2005 to June 2026, following PRISMA guidelines. Random-effects meta-analyses generated pooled prevalence estimates.

Of 6486 studies screened, 22 met the inclusion criteria. Overall, 41% were at low, 23% moderate and 36% high risk of bias.

Across 3390 participants with constipation, the pooled prevalence of eating pathology was 23%(95%CI:14%-36%). Prevalence of disordered eating and eating disorders was 34%(95%CI:18%-54%) and 17%(95%CI:9%-28%), respectively.

Across 1342 participants with FI, the pooled prevalence of eating pathology was 43%(95%CI:29%-58%). Prevalence of disordered eating and eating disorders was 42%(95%CI:27%-60%) and 44%(95%CI:15%-79%), respectively.

Avoidant/restrictive food intake disorder (ARFID) was the most assessed eating disorder, with a pooled prevalence 29%(95%CI:22%-37%) among 651 participants with constipation.

Despite limited studies, eating pathology appears common in constipation and FI populations. These findings highlight an under-recognised burden and support further research to better characterise behaviours and evaluate targeted dietary support.

Figures and tables

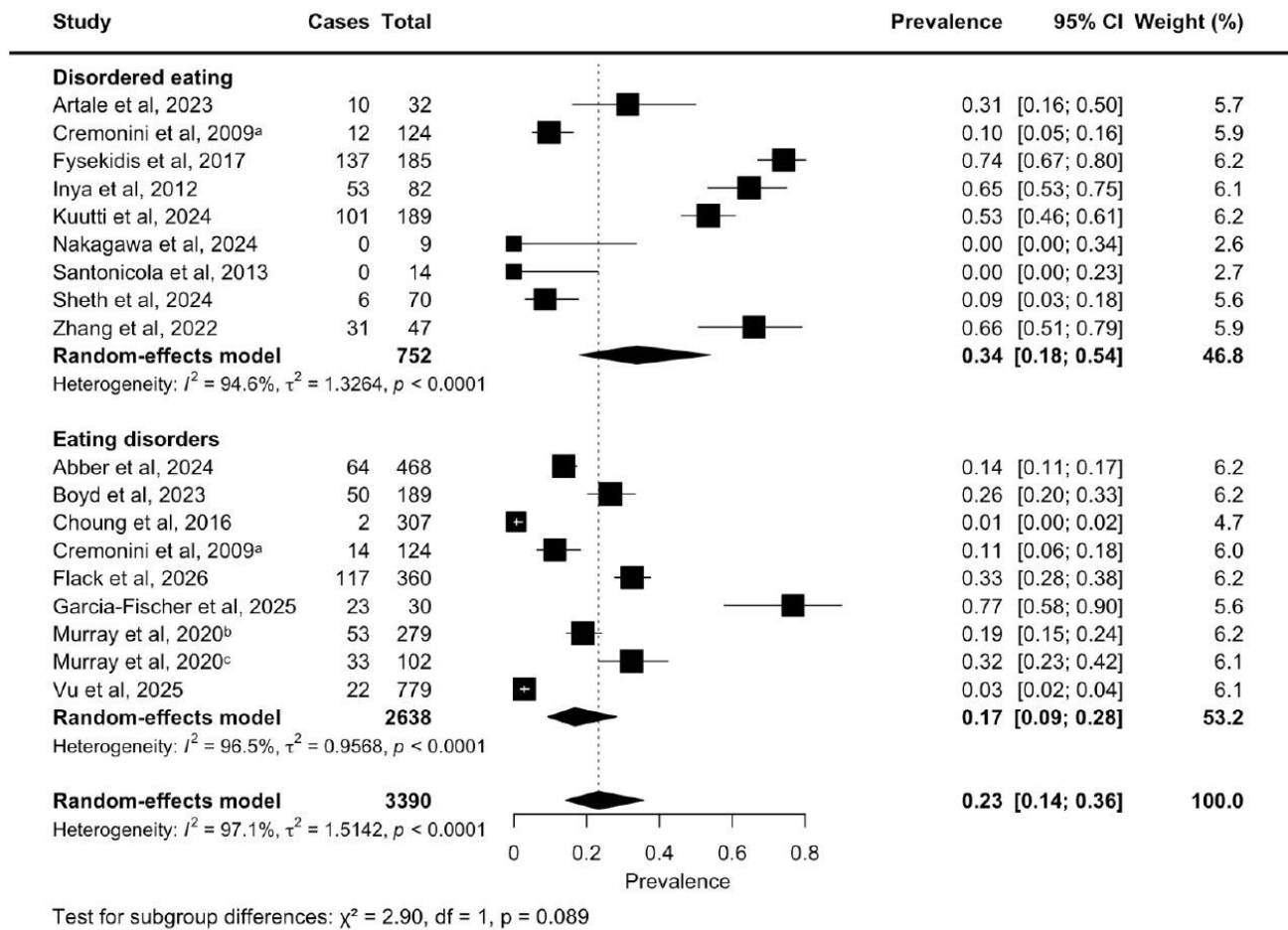


Figure 1. Forest plot showing the pooled prevalence and associated 95% confidence intervals (CIs) of disordered eating and eating disorders in constipation populations using a random-effects model. Subgroup differences were assessed using a χ^2 test, and heterogeneity using I^2 and τ^2 . Squares represent individual study prevalence estimates, with size proportional to study weight. Horizontal lines represent 95% CIs.

^a Estimates derived from the same study population

^{b,c} Denote separate studies from the same author

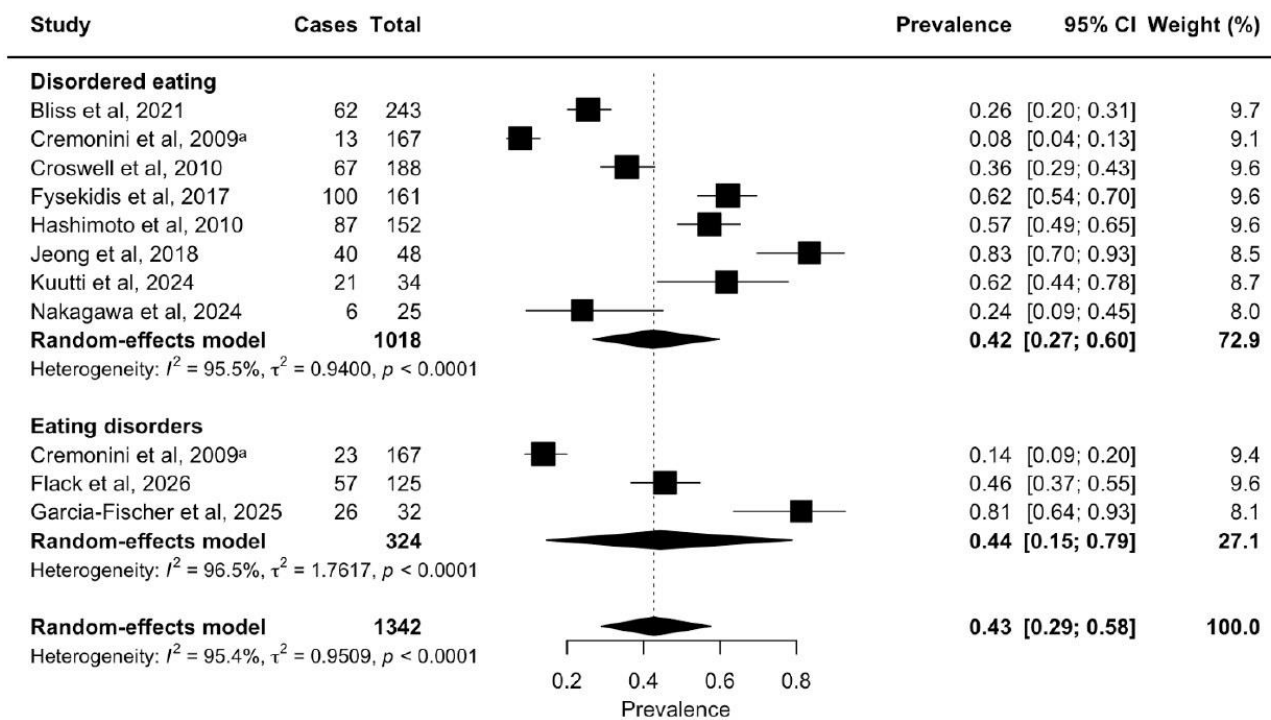


Figure 2. Forest plot showing the pooled prevalence and associated 95% confidence intervals (CIs) of disordered eating and eating disorders in faecal incontinence populations using a random-effects model. Subgroup differences were assessed using a χ^2 test, and heterogeneity using I^2 and τ^2 . Squares represent individual study prevalence estimates, with size proportional to study weight. Horizontal lines represent 95% CIs.

^a Estimates derived from the same study population

Surgical Choice and Regret in Older Adults: A Comparison of Delorme's Procedure and Ventral Mesh Rectopexy for Full-thickness Rectal Prolapse Repair

Presenting author: Wai Miu Emma Liu (Undergraduate medical student)

Institution: King's College London

Co-authors: Tanzeela Gala², Amy Silver², Linda Ferrari², Alexis Schizas², Alison Hainsworth²

²Pelvic Floor Unit, Guy's and St Thomas' NHS Foundation Trust, London, United Kingdom

Introduction

Ventral mesh rectopexy (VMR) and Delorme's procedures are commonly used to repair full-thickness rectal prolapse (FTRP). Comparative evidence on outcomes and regret in older adults is limited. We examined postoperative outcomes and regret in patients aged ≥ 70 who underwent a VMR or Delorme's procedure for FTRP.

Methods

Patients ≥ 70 undergoing VMR or Delorme's procedure for FTRP from 2014-2025 were included. Baseline characteristics, surgical details, recurrence and postoperative symptoms (faecal incontinence (FI) and incomplete emptying) were extracted. The Ottawa Decision Regret Scale measured regret in three categories: no, mild, or moderate-to-severe.

Results

Thirty-two patients were included: 23 with VMR (71.9%), and 9 with Delorme's procedure (28.1%). High take-off prolapse was more common in VMR, whilst the Delorme's had low take-off ($p=.003$).

In VMR, 78.3% had no regret, and 21.7% had regret (17.4% mild, 4.3% moderate-to-severe). In Delorme's, 33.3% had no regret, and 66.7% had regret (55.6% mild, 11.1% moderate-to-severe).

Overall, higher regret rate was seen in the Delorme's ($p=.035$). Higher regret levels were associated with Delorme's compared to VMR ($p=.039$). In VMR group, higher regret presence seen in those with postoperative FI than those without ($p=.033$). No association was found between regret and recurrence or incomplete emptying in VMR. No association was found between regret and recurrence, incomplete emptying or FI in Delorme's.

Conclusion

Amongst older adults undergoing surgery for FTRP, the Delorme's was associated with higher reports and levels of regret compared with the VMR. However, amongst VMR patients, postoperative FI appeared to contribute to regret. These findings highlight the importance of procedure selection, preoperative counselling and postoperative expectations in optimising patient satisfaction.

Figures and tables

Table 1. Baseline characteristics and postoperative outcomes between the patient cohorts

	VMR (n=23)	Delorme's (n=9)	p-value
Baseline Characteristics			
Age, Median (range)	77 (71-87)	82 (72-93)	0.097
Recurrent prolapse			
No	9 (39.1%)	7 (77.8%)	
Yes	14 (60.9%)	2 (22.2%)	0.113
Take off			
High	19 (82.6%)	2 (22.2%)	
Low	4 (17.4%)	7 (77.8%)	0.003
Other features			
Rectocele	10 (43.5%)	1 (11.1%)	0.065
Enterocoele	6 (26.1%)	2 (22.2%)	0.771
Perineal descent	14 (60.9%)	3 (33.3%)	0.065
Postoperative Outcomes			
Follow up time (months), Median (range)	42 (6-126)	17 (2-81)	0.232
Postoperative outcomes			
Incomplete emptying	10 (43.5%)	2 (22.2%)	0.422
Faecal Incontinence	8 (34.8%)	4 (44.4%)	0.696
Both	4 (17.4%)	1 (11.1%)	1.000
Postoperative Recurrence	6 (26.1%)	1 (11.1%)	0.640

Table 2. Association between postoperative symptoms or recurrence and surgery type with presence of regret

	VMR		OR	p-value ^a	Delorme's		OR	p-value ^a
	No Regret	Regret			No Regret	Regret		
Overall	18 (78.3%)	5 (21.7%)	-	-	3 (33.3%)	6 (66.7%)	-	0.035
Recurrence								
Y	3 (50.0%)	3 (50.0%)			0	1 (100%)		
N	15 (88.2%)	2 (11.8%)	7.50 (0.85-66.1)	0.089	3 (37.5%)	5 (62.5%)	0.63 (0.37-1.07)	1.000
Postoperative Symptoms								
Faecal incontinence								
Y	4 (50.0%)	4 (50.0%)			2 (50.0%)	2 (50.0%)		
N	14 (93.3%)	1 (6.7%)	14.0 (1.2-163.4)	0.033	1 (20.0%)	4 (80.0%)	0.25 (0.01-4.73)	0.524
Incomplete emptying								
Y	8 (80.0%)	2 (20.0%)			1 (50.0%)	1 (50.0%)		
N	10 (76.9%)	3 (23.1%)	0.83 (0.11-6.26)	1.00	2 (28.6%)	5 (71.4%)	0.40 (0.01-10.0)	1.000

^a p-value from two-sided Fisher's test

Assessment of segmental anal canal distensibility in incontinent patients with and without recto-anal rectal intussusception using EndoFLIP

Presenting author: Matthew Davenport (Surgical / medical trainee)

Institution: Manchester University NHS Foundation Trust

Co-authors: Alex O'Connor^{1,3}, Donghua Liao², Abhiram Sharma¹, Gemma Faulkner¹, Dipesh Vasant^{1,3}, John McLaughlin³, Ed Kiff¹, Karen Telford^{1,3}

¹Manchester University NHS Foundation Trust

²Aalborg University Hospital

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Introduction

Recto-anal rectal intussusception (RAI) is associated with faecal incontinence (FI). This may be due to the intussusceptum causing damage to the sphincter complex due to the repeated stretching/dilating effect in the proximal anal canal. If so, the sphincter complex would be disproportionately weakened proximally. EndoFLIP allows us to investigate this by assessing anal canal distensibility at multiple points along its length.

Methods

Patients with FI, who had undergone proctography, underwent EndoFLIP assessment. Segmental distensibility indexes (DI) at the narrowest point, mid-canal and proximal canal were calculated whilst performing the 'ramp' EndoFLIP protocol. This involves assessment of distensibility (at rest and during squeeze) as the EndoFLIP balloon is inflated then deflated with sequentially increasing 10ml increments of saline (from 10-50ml).

Results

47 patients were recruited (RAI = 26, No RAI = 21). In the group with No RAI, 5 had recto-rectal intussusception, 16 had no intussusception on proctography. There were no significant differences in age, parity, gender, incidence of sphincter defects or FI symptom severity (Vaizey score) between the two groups. There was no significant difference in segmental DIs at rest or during squeeze. However, the proximal canal DI, when taken as a ratio of mid-canal DI, was significantly higher in those with RAI ($P=0.03$) during in the 50ml inflation whilst the patient was squeezing.

Conclusion

In patients with FI, RAI appears to disproportionately affect the proximal anal canal distensibility when taken a ratio of mid-canal distensibility. This would support the hypothesis that RAI causes mechanical damage to the proximal anal sphincter complex.



Video abstracts

Shown during the poster session · Friday 6 November, 08:00 – 09:00 · Mandolay Suite

Combined Robotic Ventral Mesh Rectopexy and Laparoscopic Sacrocolpopexy for Multicompartment Pelvic Organ Prolapse

Presenting author: Sumathi Nadikuditi (Surgical / medical trainee)

Institution: Ninewells Hospital

Co-authors: Dorin Ziyaie¹, Kirsty Mozolowski¹, Zbigniew Tkacz², Kenneth Campbell¹.

¹Ninewells Hospital, Colorectal surgery, Dundee, United Kingdom.

²Ninewells Hospital, Gynaecology, Dundee, United Kingdom.

This video demonstrates a single-stage, minimally invasive repair of coexisting external rectal prolapse and apical vaginal vault prolapse in an elderly patient. Following multidisciplinary assessment, robotic ventral mesh rectopexy was combined with laparoscopic sacrocolpopexy using shared ports and robotic optics. Key steps include ventral rectovaginal dissection preserving autonomic nerves, biological mesh fixation to the anterior rectum, two-limb synthetic mesh placement for vaginal apical support, and fixation of both meshes to the sacral promontory with complete re-peritonealisation. Recovery was uneventful with no complications. This combined approach offers durable anatomical restoration and excellent functional outcomes while minimising nerve injury risk.

Sphincter Preserving Proctectomy for Recurrent Rectal Prolapse

Presenting author: Mamata Battili (Surgical / medical trainee)

Institution: NHS Tayside

Co-authors: Dorin Ziyaie¹

¹Ninewells Hospital, NHS Tayside, Dundee

Recurrent rectal prolapse is challenging to treat in elderly women with active quality of life. We present a case of an 83-year-old female with recurrent rectal prolapse despite five abdominal repairs over twenty years including posterior sutured and ventral mesh rectopexies. She was finally offered a RAS end-colostomy with sphincter-preserving proctectomy, sparing both internal and external anal sphincters, performed in an Altemeier's fashion. The internal sphincter was used for closure of anal canal to minimise perineal complications like hernia and dehiscence in an otherwise attenuated pelvic floor. The patient achieved satisfactory quality of life with no complications on one-year follow-up.



Posters

Poster session · Friday 6 November, 08:00 – 09:00 · Mandolay Suite

Impact of postpartum pelvic floor dysfunction: a qualitative systematic review and metaggregation

Presenting author: Elizabeth Doxford-Hook (Surgical / medical trainee)

Institution: University of Leeds

Co-authors: Elizabeth Doxford-Hook¹, Linda McGowan¹, Candice Downey², Ranee Thakar³, Naomi Berwin⁴, Yu Fu⁵

¹School of Healthcare, University of Leeds, Leeds

²Sheffield Teaching Hospitals, Sheffield

³Croydon Health Services NHS Trust, Croydon

⁴Patient and Public Involvement and Engagement partner, Leeds

⁵Primary Care and Mental Health, University of Liverpool, Liverpool

Introduction

Childbirth is a transformative time in a woman's life, marking the beginning of a new journey into motherhood however it can also be accompanied by a myriad of physical changes to the pelvic floor (vaginal prolapse, urinary incontinence (UI), sexual dysfunction and/or anal incontinence (AI)). The impact of this condition reaches far beyond the physical symptoms, compromising overall quality of life and is a significant risk factor for the development of post-partum depression (1,2)(3,4). The condition is poorly acknowledged by healthcare professionals.

Objective

This review explores the experiences of women with postpartum pelvic floor dysfunction and their healthcare needs.

Inclusion Criteria: The review will consider studies that include women aged 18 and over, from any ethnicity, location or setting, who have symptoms of postpartum PFD within one year of childbirth. These symptoms can be self-reported or diagnosed.

Methods

The review was conducted according to the Joanna Briggs Institute methodology for systematic reviews of qualitative evidence. Medline, EMBASE, CINAHL, the Cochrane Library, Maternity and Infant Care and PsycINFO were searched. Studies published in English and published since 1999 were included. All studies identified were examined against the inclusion criteria. Papers selected for inclusion were assessed by 4 independent reviewers for methodological quality. Qualitative research findings were pooled, findings were collated, categorised and subject to metaaggregation to produce a comprehensive set of synthesised findings.

Results

Twenty-six papers were deemed relevant to the review question. Most papers focussed on experiences of UI, only one on sexual dysfunction. Broadly the synthesised findings relate to perceived normality of symptoms, shame, loss of self of self and advocating for more. There were also themes of poor communication and knowledge about the condition.

Conclusions

This is the first systematic review to summarise the experience of women with postpartum PFD. These synthesised findings can be used by organisations to develop services for women and support them in matrescence.

A systematic review investigating the association between mode of birth and long-term pelvic floor dysfunction.

Presenting author: Miriam Wassell (Undergraduate medical student)

Institution: University of Nottingham

Recent changes in NICE guidelines made caesareans more accessible, increasing the importance of determining the link between birth mode and subsequent pelvic floor disorder (PFD). PFD encompasses: pelvic organ prolapse (POP), urinary incontinence (UI), faecal incontinence (FI) and sexual dysfunction. This review aims to determine the link between mode of birth and PFD, and evaluate the suitability of current NICE guidelines. Methods: 1. Systematic review - a literature search was performed using three databases, following the PRISMA guidelines. Next, papers were relevance screened and assessed for bias using CASP checklists. 2. Prosection displaying the superficial perineal pouch. Results: Twenty-four papers across eleven countries, representing 42,003 patients were selected. In POP, UI, and FI caesareans were found to be protective against future PFD, compared to spontaneous vaginal deliveries (SVD) and operative vaginal deliveries. In sexual dysfunction a higher incidence was found following caesareans compared to SVDs. Discussion and conclusion: A geographical skew in the data made it unlikely to be globally representative, owing to differences in post-partum care, education and parity. Current NICE guidelines do not advise discussion of future PFDs, meaning people in the UK may not be appropriately informed when deciding on how to give birth.

Patient Satisfaction, Quality of Life and Continence Status Following Surgical Treatment of Pelvic Floor Damage Using the Modified Preanal Repair Method: A Retrospective Follow-up Survey

Presenting author: Daniel Weber (Postgraduate student in a discipline related to pelvic health)

Institution: University Medical Center Schleswig-Holstein, Kiel, Germany

Co-authors: Thomas Becker¹, Mathias Löhnert^{1,2}

¹Department of General, Visceral, Thoracic, Transplant and Paediatric Surgery, University Medical Center Schleswig-Holstein, Campus Kiel, and / Faculty of Medicine, Kiel University, Kiel, Germany

²Department of General Surgery and Coloproctology, Klinikum Bielefeld-Rosenhöhe, Bielefeld, Germany

Introduction

For complex pelvic floor damage, the modified Preanal Repair (mPAR) combines rectocele repair and ventral pelvic floor stabilisation with modified sphincter reconstruction. Scar tissue is folded inward and sutured as internal reinforcement rather than resected, preserving continuity of the sphincter-scar complex. Patient-reported satisfaction, quality of life and continence were assessed.

Methods

Women undergoing mPAR for pelvic floor damage at one centre during 2014-2023 were surveyed retrospectively by post. Continence and quality of life were assessed using the Continence Score of the Surgical Working Group for Coloproctology (CACP score), the Questionnaire on Quality of Life in Anal Incontinence (FLQAI; German version of the Fecal Incontinence Quality of Life Scale [FIQL]) and a study-specific questionnaire. Analyses included descriptive statistics, Spearman correlation and Mann-Whitney U tests.

Results

Of 226 patients contacted, 122 were included. Median follow-up was 5.5 years [IQR 2.4-8.6]. Among evaluable participants, 89/118 (75.4%) would undergo surgery again and 77/118 (65.3%) reported sustained improvement in quality of life. Mean FLQAI subscale scores reached 67.3-76.8% of their maxima, indicating favourable quality of life. The CACP score classified 46/84 (54.8%) as continent, 33/84 (39.3%) as partially continent and 5/84 (6.0%) as incontinent. Follow-up duration was not significantly associated with CACP score ($p=0.305$) or any FLQAI subscale (all $p \geq 0.150$). Age at surgery was not significantly associated with continence ($p=0.052$) or sustained symptom improvement ($p=0.094$).

Conclusion

Favourable outcomes suggest clinically relevant long-term benefit from mPAR. The retrospective design without preoperative baseline data or a control group precludes causal inference; prospective controlled studies are required.

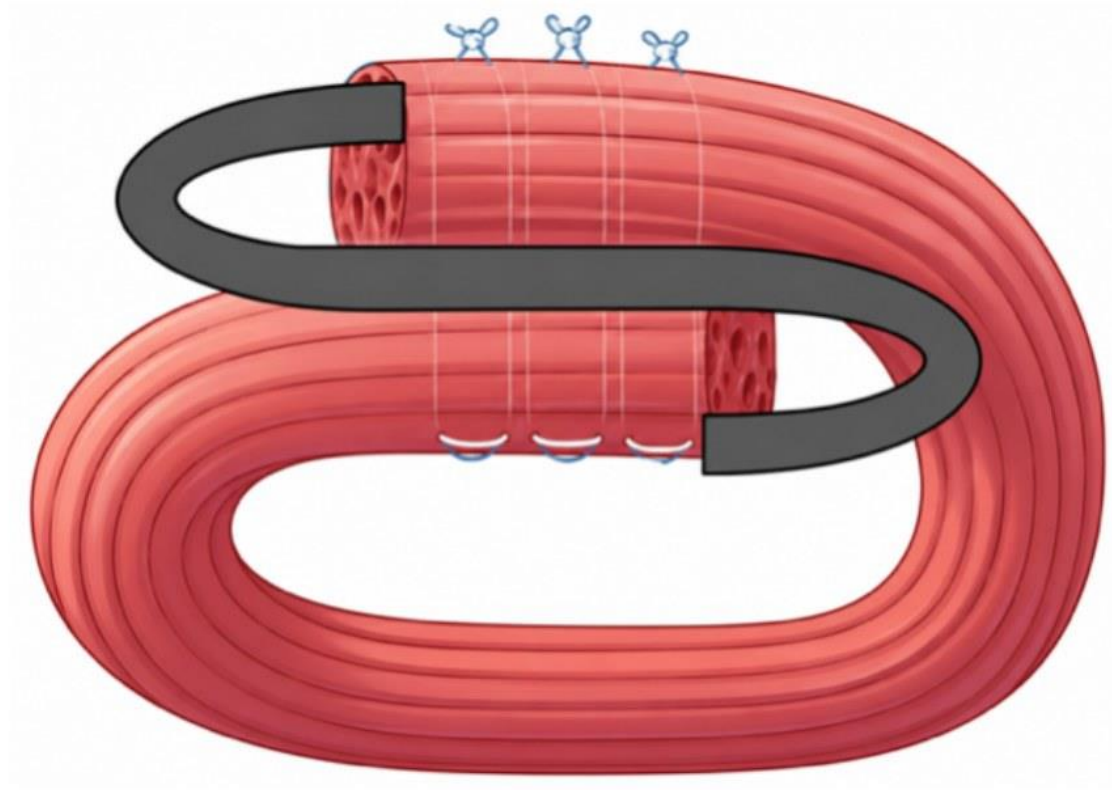


Fig. 1. Technique of overlapping sphincter reconstruction without resection, including in long-standing defects. The scarred area (grey) is left in situ. Bilateral lateral mobilisation of the sphincter allows the mobilised portions to be overlapped and subsequently sutured.

Prevalence of Gastrointestinal Symptoms in Endometriosis: A Systematic Review

Presenting author: Grazielle De Araujo Perini (Undergraduate medical student)

Institution: Imperial College School of Medicine

Co-authors: Grazielle De Araujo Perini^{1,4}, Tariq Miskry², Zirong Song^{1,4}, Amarachi Ohanusi^{1,4}, Symriti Kaur-Panesar^{1,4}, Chiara Dell'Oro^{1,4}, Rachel Fernandes^{1,4}, Emma V. Carrington^{3,4}

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Objective

Gastrointestinal (GI) symptoms are common in endometriosis and may contribute to disease burden and diagnostic difficulty, yet their prevalence remains poorly characterised. We aimed to synthesise evidence on the prevalence and reporting of GI symptoms in women with endometriosis.

Design:

Systematic review, prospectively registered on PROSPERO (CRD420261331058).

Methods

MEDLINE, Embase and Scopus were searched for studies published between 2000 and 2026 reporting GI symptom prevalence in adults with endometriosis. Titles and abstracts were independently screened by six reviewers, followed by full-text screening and data extraction using predefined criteria. Risk of bias was assessed using adapted Newcastle-Ottawa and Cochrane Risk of Bias 2 tools. Symptom prevalence was summarised using medians and interquartile ranges (IQRs).

Results

Of 6,342 records identified, 4,315 were screened and 50 studies comprising 17,003 women were included. Most studies had moderate risk of bias (56%). Dyschezia was reported in 41 studies (median prevalence 44.2%, IQR 32.8%) and constipation in 23 (42.3%, IQR 28.5%). Evacuatory difficulty and faecal urgency were each reported in 4 studies, with median prevalences of 61.9% and 56.5%, respectively. Bloating was reported in 11 studies (53.4%) and diarrhoea in 18 (25.6%, IQR 35.4%). Upper GI symptoms were less frequently investigated.

Conclusion

GI symptoms are highly prevalent in endometriosis, particularly evacuatory difficulty and faecal urgency, but inconsistent definitions and reporting limit comparisons. Standardised GI symptom assessment may improve recognition and facilitate targeted management, potentially reducing disease burden and improving quality of life.

Figures and tables

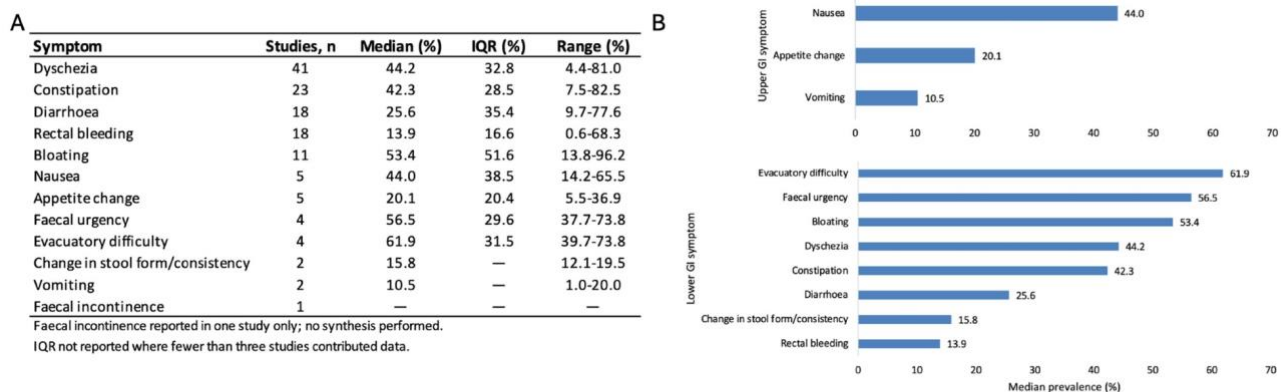


Figure 1. Summary of the reported prevalence of GI symptoms across included studies.

Panel A describes median, interquartile range (IQR) and range of reported GI symptom prevalence across included studies. Panel B is a bar chart comparing median of reported lower GI and general symptom prevalence across included studies. Lower GI symptoms included dyschezia, constipation, diarrhoea, rectal bleeding, faecal urgency, evacuatory difficulty, change in stool form or consistency, faecal incontinence and bloating. Upper GI symptoms included nausea, vomiting and appetite change. Median prevalence, IQR and range are presented for each symptom based on available study-level data. Variability measures were not calculated where fewer than three studies reported prevalence data. Faecal incontinence was reported in only one study, precluding summary estimates.

Gut Microbiota Dysbiosis in Irritable Bowel Syndrome and its Relationship with Anxiety and Depression: A Narrative Review

Presenting author: Rudrani De (Undergraduate medical student)

Institution: University of Buckingham

¹University of Buckingham, Buckinghamshire

Abstract:

Background

Irritable Bowel Syndrome (IBS) remains a complex gastrointestinal disorder with a pathophysiology that is still not fully understood. Recent evidence highlights the Gut- Brain Axis (GBA) as a bidirectional link between intestinal functions and the central nervous system. This narrative review specifically investigates the imbalances in gut bacteria and its correlation with Generalized Anxiety Disorder (GAD) and depression within IBS populations.

Methods

A thorough systemic search of PubMed, Cochrane Library, and MEDLINE was performed for articles up to October 2024. Eleven primary research articles met the inclusion criteria, which included adult participants (n>100) and clinical diagnosis of IBS and mental health disorders. Methods analysed included 16S rRNA sequencing and quantitative PCR of stool samples.

Results

The review of 11 primary studies (≥100 participants, Rome III/IV IBS, DSM-IV anxiety/depression) revealed consistent gut-microbiota alterations in IBS patients with comorbid anxiety or depression. All 8 investigations reporting α-diversity showed a reduction in IBS versus healthy controls, with marked loss of Lachnospiraceae and Ruminococcaceae and enrichment of Proteobacteria and Prevotella; a shift toward a lower Firmicutes/Bacteroidetes ratio viewed a significant correlation with higher anxiety or depressive scores.

Distinct microbial biomarkers—variations in Firmicutes, Bacteroidetes, and Actinobacteria— were found to differ between IBS subtypes, aiding to diagnosis. Neurotransmitter assays indicated positive correlations of norepinephrine with Bacteroidetes and plasma serotonin with Proteoglycans, while Firmicutes showed a negative association with norepinephrine.

Ultimately, these findings help support a bidirectional gut-brain axis linking dysbiosis to mental health disorders – anxiety and depression, suggesting that species-level, multicentre trials and microbiome-targeted therapies are needed to validate causal mechanisms and develop interventions for personalized care for the near future.

Image + Table from the Narrative Review

Study	Study Design	Population	Methodology	Key Findings	Relevance
<u>Jeffery et al. (2011)</u>	Observational	IBS patients vs controls	16S rRNA sequencing	Distinct microbiota subtypes in IBS	Supports microbial dysbiosis in IBS
<u>Tap et al. (2017)</u>	Observational	IBS patients	Microbiome sequencing + symptom scoring	Microbiota composition linked to IBS severity	Links microbiota with symptom severity
<u>Liu et al. (2016)</u>	Case-control	IBS-D & depression patients	Microbiome analysis	Similar microbiota profiles in IBS-D & depression	Supports gut-brain axis
<u>Zhu et al. (2019)</u>	Observational	IBS subtypes	16S rRNA sequencing	Subtype-specific microbiota alterations	Highlights IBS heterogeneity
<u>Agnello et al. (2020)</u>	Observational	IBS patients	Microbiome profiling	Altered gut microbiome composition in IBS	Confirms dysbiosis
<u>Hugerth et al. (2020)</u>	Population-based	IBS vs general population	Microbiome sequencing	No consistent microbiome signature	Shows conflicting evidence
<u>Simpson et al. (2021)</u>	Systematic review	Anxiety & depression	Literature synthesis	Microbiota linked to mental health	Supports gut-brain axis
<u>Barandouzi et al. (2022)</u>	Observational	IBS + psychological symptoms	Microbiome sequencing	Altered microbiota in IBS with mental comorbidities	Links IBS + mental health
<u>Pittayano et al. (2019)</u>	Systematic review	IBS patients	Meta-analysis	Reduced diversity & altered taxa in IBS	Strong evidence for dysbiosis
<u>Wang et al. (2020)</u>	Meta-analysis	IBS patients	Meta-analysis of case-control studies	Significant microbial differences vs controls	Confirms microbiome alterations

<u>Shrestha et al. (2022)</u>	Systematic review	IBS patients	Literature review	Microbiota involved in IBS pathophysiology	Mechanistic understanding
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5.1. Fig shows a summary of the 11 primary research articles taken into consideration for this review.

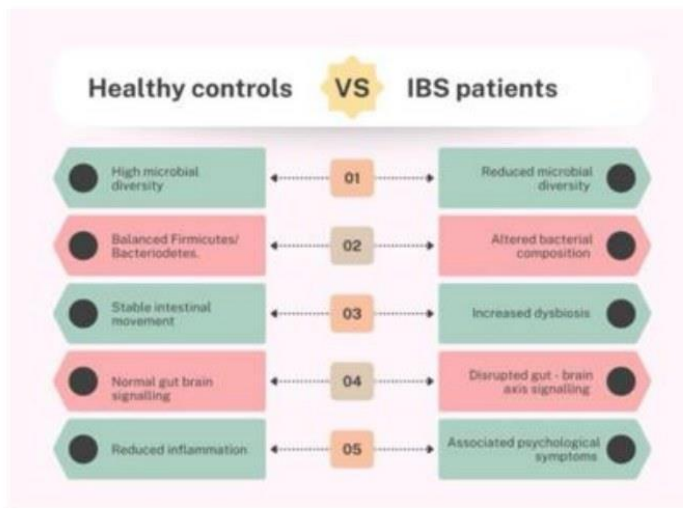


Fig. 4.1.1- Conceptual comparison between healthy controls and IBS patients. (Jeffery 2011, Pittayanon et al., 2019, Wang et al., 2020, Arzani et al., 2022).

Changing goalposts: the implications of the new Rome V criteria for dyssynergia defecation for pelvic floor services

Presenting author: Charlotte Keyse (Postgraduate student in a discipline related to pelvic health)

Institution: Manchester University NHS Foundation Trust

Co-authors: Charlotte Keyse¹, Sharon Archbold¹, Charlotte Pitcher¹, Dipesh Vasant¹

¹Neurogastroenterology Unit, Wythenshawe Hospital, Manchester University NHS Foundation Trust

Introduction

Rome V anorectal disorders recently broadened the diagnostic criteria of Dyssynergic Defecation (DD). Whereas Rome IV required two abnormal tests from anorectal manometry (ARM), balloon expulsion test (BET), or defecography (DP), Rome V only requires one abnormal test.

Methods

Consecutive patients with defecatory symptoms that underwent ARM + BET at a tertiary Neurogastroenterology and Pelvic Floor Unit between May 2024 and May 2026 were included. Abnormal ARM was defined as rectal propulsive force <45mmHg or anal canal relaxation <20%. An abnormal BET was >60s. DP reports describing “incomplete emptying”, or “>20% of neostool retained” were classified as abnormal. We compared the yield of Rome IV and Rome V based on investigation findings and their utility.

Results

200 patients with defecatory symptoms underwent anorectal physiology, of which 62% also completed DP. 115 (58%) met the Rome IV criteria, whereas 183 (92%) met the Rome V criteria for DD, representing a 59% increase. In terms of the utility of the tests used, abnormal rectal propulsion on ARM was associated with abnormal BET ($p<0.001$) and abnormal DP ($p<0.012$). BET and DP were also significantly associated ($p<0.001$). By contrast, anal canal relaxation on ARM was not associated with either BET or DP.

Conclusions

Application of Rome V resulted in 59% increase in the number of patients that would be likely to benefit from conservative therapies without initially needing to have both anorectal physiology and DP. Services need to be prepared for the large, anticipated increase in referrals to avoid systems being overwhelmed.

Impact of pre-procedure telephone assessment on attendance, compliance and completion of insourced urodynamics clinics versus NHS urodynamics clinics: A service evaluation.

Presenting author: Rebecca Hall (Nurse / allied health professional)

Institution: Manchester University NHS Foundation Trust

Co-authors: Leah Carman¹

¹Manchester University NHS Foundation Trust

Introduction

Insourcing clinics provide additional capacity to support NHS waiting-list recovery. In our service, patients attending insourced urodynamics clinics receive a prior telephone assessment, to obtain a clinical history and reinforce pre-procedure instructions including medication cessation and bladder diary completion. This service evaluation compared non-attendance (DNA), successful urodynamics completion and pre-procedure compliance between insourced clinics with telephone assessment and NHS clinics without.

Methods

Retrospective data were collected for patients booked for insourced or standard NHS urodynamics between 1 July and 20 August 2026. Electronic records were reviewed for DNA and cancellation rates, medication and bladder diary compliance, and reasons for urodynamics not being performed. Significance was determined using two-sided Fisher's exact test.

Results

The DNA rate was lower in the insourcing group than the NHS group (5.9% vs 10.4% [Table 1]). Of those that attended clinic, urodynamics was completed in 95% of insourcing versus 79% of NHS clinics. Medication cessation among patients prescribed OAB medication was 100% versus 78%, while 3-day bladder diary completion was 54% versus 34% in the insourcing versus NHS clinics, respectively. Overall, the conversion from booked appointment to completed urodynamic investigation was 74.5% for insourced clinics compared with 67.2% for standard NHS clinics (Table 2). However, none of the outcomes assessed differed significantly.

Conclusion

Pre-procedure telephone assessment showed a trend towards improved clinic attendance, greater compliance with pre-procedure requirements and better conversion rates from booked to successfully completed investigations, although without statistical significance. Telephone assessment may improve patient preparedness and optimise diagnostic capacity.

Figures and tables

Table 1: Outcomes for patients **booked** into clinic

Outcome	Insourcing Urodynamics clinic	Standard NHS urodynamics clinic	<i>p-value*</i>
Total number of patients booked	51	67	
DNA rate	5.9% (3/51)	10.4% (7/67)	0.38
Cancellations (Hospital/patient)	15.7% (8/51)	10.4% (7/67)	0.39

* $p < 0.05$ determined significance

Table 2: Outcomes for patients who **attended** clinic

Outcome	Insourcing urodynamics clinic	Standard NHS urodynamics clinic	<i>p-value</i>
Number of patients	40	53	
Total number of urodynamics tests completed	95% (38/40)	79% (45/53)	0.20
3-day bladder diary completed	54% (21/40)	34% (18/53)	0.08
Number of patients being treated with OAB medication	25% (10)	34% (18)	0.48
Medication stopped correctly	100% (10/10)	78% (14/18)	0.25
Urodynamics not performed for other reasons	5% (2/40)*	7.5% (4/53)**	1.00
Overall			
Successful urodynamics per patient booked	74.5% (38/51)	67.2% (45/67)	0.45

*Two patients had urinary tract infection which is a contraindication to urodynamics

**Two patients required bladder retraining prior to urodynamics, one patient declined due to inadequate pre-clinic information, and one patient had previously undergone urodynamics.

Faecal Incontinence: Is it Right to ROME?

Presenting author: James Barry (Surgical / medical trainee)

Institution: University Hospital of North Durham

Co-authors: Kingston, A.¹ Ruffle, J.² Knowles, C, H.³ Yiannakou, Y.⁴ Noblett⁴

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Background

Since 1992 the Rome Foundation has developed diagnostic criteria for disorders of gut–brain interaction. For faecal incontinence (FI), successive iterations have adopted increasingly restrictive criteria. Whether this excludes individuals with clinically meaningful symptoms remains uncertain.

Methods

An anonymous online FI questionnaire was distributed to members of the Research+ME and ContactMe-IBS registries. Data included recognised risk factors, FI frequency, Vaizey severity score, and patient-reported impact on mood, work productivity and activities of daily living (ADLs) using 0–10 Likert scales. Participants were stratified according to Rome III and Rome IV criteria.

Results

Overall, 1,209 (35.7%) respondents reported FI; 687 (20.3%) met Rome III and 509 (15.0%) Rome IV criteria. Vaizey scores increased with FI frequency ($\beta=1.01$, $p<0.001$), with mean scores of 8.21 (All FI), 9.42 (Rome III) and 10.49 (Rome IV). Rome IV excluded 127 (10.5%) individuals with Vaizey scores >12 .

Patient-reported impact on mood, ADLs and work productivity increased with progressively restrictive criteria (all $p<0.001$); however, post hoc analysis showed significant differences only between Rome IV and All-FI groups. Individuals not meeting Rome criteria still reported maximal impact across all psychosocial domains.

Rome criteria strengthened the adjusted association (aOR) between diarrhoea and FI while rendering those with high BMI, hypermobility and receptive anal intercourse non-significant.

Conclusions

Although standardised criteria facilitate research, increasingly restrictive Rome criteria exclude individuals with substantial symptom burden, alter observed risk factor associations and reduce population representativeness. This suggests caution when applying ROME criteria in isolation in FI research and clinical practice

Faecal Incontinence and its Risk Factors: An Update

Presenting author: James Barry (Surgical / medical trainee)

Institution: University Hospital of North Durham

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³Queen Mary University of London, London

⁴University Hospital of North Durham, Durham.

Background

Faecal incontinence (FI) is a multifactorial condition affecting millions worldwide. Historically, literature has focused on obstetric risk factors, particularly obstetric anal sphincter injury (OASI). More recently, diarrhoea, with or without irritable bowel syndrome (IBS), has emerged as a major contributor. As initial assessment is often through general surgical services, earlier gastroenterology input may complement multidisciplinary assessment. This study compared gastrointestinal and obstetric determinants of FI in a large UK community cohort.

Methods

An anonymous online questionnaire was completed by 3,384 participants recruited from the NHS Research+ME and ContactME-IBS registries. Data on recognised FI risk factors and demographic characteristics were collected. Multivariable regression analysis adjusted for key confounders and recruitment source.

Results

Overall, 35.7% (n=1,209) reported FI (30.5% in Research+ME; 55.2% in ContactME-IBS). After adjustment, diarrhoea was the strongest predictor of FI (aOR 4.11, 3.42–4.95), followed by IBS (aOR 2.08, 1.67–2.60) and cumulative medical comorbidity (aOR 1.60, 1.41–1.81).

Females had 22% higher odds of FI than males (aOR 1.22, 1.00–1.49). Obstetric tears increased the odds of FI by 30% (aOR 1.30, 1.01–1.67), rising to 2.10 (1.21–3.65) for OASI. Diarrhoea strongly predicted FI frequency (aOR 5.01, p<0.001) and Vaizey severity ($\beta=1.89$, p<0.001), with a dose-response relationship. No obstetric factor independently predicted greater FI severity.

Conclusions

Diarrhoea is the dominant predictor of FI presence and severity, while OASI remains an important but comparatively smaller contributor. Clinical assessment should prioritise identifying causes of loose stools, with earlier gastroenterology assessment considered for selected patients within multidisciplinary continence care.

A Single-Centre, 25-Year Experience in the Surgical Management of Constipation

Presenting author: James Barry (Surgical / medical trainee)

Institution: University Hospital of North Durham

Co-authors: Volak, D¹ Yiannakou, Y¹ Noblett, S¹

Background

Severe constipation refractory to standard measures can significantly impact quality of life. Management is challenging, often focused on symptom control rather than cure. Surgery is rarely indicated, with sustained benefit uncertain and prospective study challenging given low intervention frequency. We evaluated long-term surgical outcomes at a tertiary referral centre.

Methods

Patients undergoing colectomy (n=22, 2003-2009), appendicostomy (ACE; n=23, 2013 onwards) or de-functioning ileostomy (n=29, 2013 onwards) for constipation were retrospectively reviewed for pre-operative diagnoses, complications, chronic pain, symptom recurrence, intervention failure and reversal.

Results

Following colectomy (22 female; mean age 37.9), mean follow-up was 14.2 years. Complications included chronic pain (72.7%), re-laparotomy <30 days (18.2%), small bowel obstruction (22.7%), incisional hernia (13.6%), and intestinal failure (13.6%). Constipation requiring medical management recurred in 55% at a mean 3.0 years, with only 15% reporting normal function.

Following ACE (22/23 female; mean age 41.8), 10 remained in use at mean 7.1 years. Twelve were reversed, predominantly for failure/ineffectiveness (n=9), with five progressing to ileostomy.

Following ileostomy (26/29 female; mean age 49.6), 22 remained in situ at mean 6.0 years and seven were reversed; mainly due to high output (n=3) and psychological difficulty (n=2). High output (37.9%) and parastomal hernia (34.5%) were common.

Conclusion

Colectomy carried substantial long-term morbidity, pain and symptom recurrence. Locally surgical practice shifted towards less invasive approaches. ACE and de-functioning ileostomy can provide sustained management in selected patients, careful patient selection and counselling are essential. Future work should assess patient satisfaction and establish a national registry for long-term outcome evaluation.

Sacral Neuromodulation is an effective treatment for Bowel Dysfunction in adult patients with childhood history of Imperforate Anus

Presenting author: Kelly Stackhouse (Nurse / allied health professional)

Institution: Sandwell and West Birmingham NHS Trust

Co-authors: Mohamed Gulamhussein, Jodie Butler, Anil Thomas George, Elizabeth Clarson

Introduction

Sacral Neuromodulation (SNM) is an effective treatment for faecal incontinence (FI) in patients with normal anatomy and anal sphincter. However, data regarding their role and effectiveness in adult patients who have FI secondary to childhood imperforate anus (IA) having had surgical reconstruction is limited with only single case reports.

Methods

Our study looked at adult patients with FI secondary to childhood reconstructive surgery due to IA who failed to have symptom improvement conservatively. All patients had baseline investigations including anorectal manometry, endoanal ultrasound and plain films to assess for sacral abnormalities. > 50% improvement in Wexner Score and/ or 50 % reduction in bowel accidents was required following temporary SNM for proceeding to permanent SNM. All patients were followed up for implant monitoring, lead migration and effectiveness as per standard protocol.

Results

5 patients in total were studied, (2M:3F). 1 patient had partial sacral agenesis, 4 normal sacra. Mean age 32.5 yrs (+/- 10.2). All patients had temporary SNM. Wexner scores improved from 17.8 (+/-8.1) to 12.6 (+/-2.49). Bowel accidents reduced from 20 (+/-9.48) to 2.6 (+/-2.05) per week. All patients proceeded to permanent SNM with 3 monthly checks; mean follow up 33 months (+/- 25.4). During this period, effectiveness had been maintained with no lead migration. One patient underwent removal of implant due to loss of efficacy at 12 months.

Conclusions

SNM is an effective treatment for faecal incontinence in adult patients with a history of imperforate anus and a background of anorectal reconstruction

Bridging the Gap: A Multicentre Evaluation of the AF500X

Presenting author: Claire Sampson (Nurse / allied health professional)

Institution: North West Anglia NHS Foundation Trust

Co-authors: Emily Ali¹, Tatenda Marunda², Tracey Perkins³, Kelly Stackhouse⁴, Laura Thomas⁵

¹Aneurin Bevan University Health Board

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Transanal irrigation (TAI) is an established bowel management intervention for patients whose symptoms remain inadequately controlled despite conservative treatment. The Aquaflush AF500X is a 500 mL irrigation system designed to bridge the gap between traditional low-volume and high-volume TAI devices. Its unique intermediate irrigation volume aims to reduce the need for more complex high-volume systems while minimising repeated low-volume irrigations. This evaluation assessed early outcomes associated with the AF500X over 3 months.

Methods

A multicentre evaluation was conducted involving 94 patients (≥18 years) with persistent bowel symptoms who had not responded adequately to conservative management (Figure 1). Symptom burden was assessed using an 11-point Likert scale ranging from 0 (not at all bothersome) to 10 (extremely bothersome). Scores were recorded before initiating TAI and reassessed after 3 months. Irrigation frequency and water volume were also reviewed.

Results

Ninety-four patients were enrolled, with 84% continuing irrigation at 3 months. Across the cohort, mean symptom bothersome scores decreased by 4.2 points. Descriptive analyses demonstrated improvements across all symptom groups evaluated (Figure 2). At 3 months, 45% of patients continued daily irrigation, while the remainder had reduced frequency to alternate-day or as-required irrigation.

Conclusion

Early findings suggest that use of the AF500X is associated with a notable reduction in symptom burden across a range of conditions traditionally managed using either low-volume or high-volume TAI systems. The high continuation rate suggests good usability, acceptability, and perceived effectiveness. Further longitudinal follow-up is required to determine whether these improvements are maintained over time

Figures and tables

Figure 1

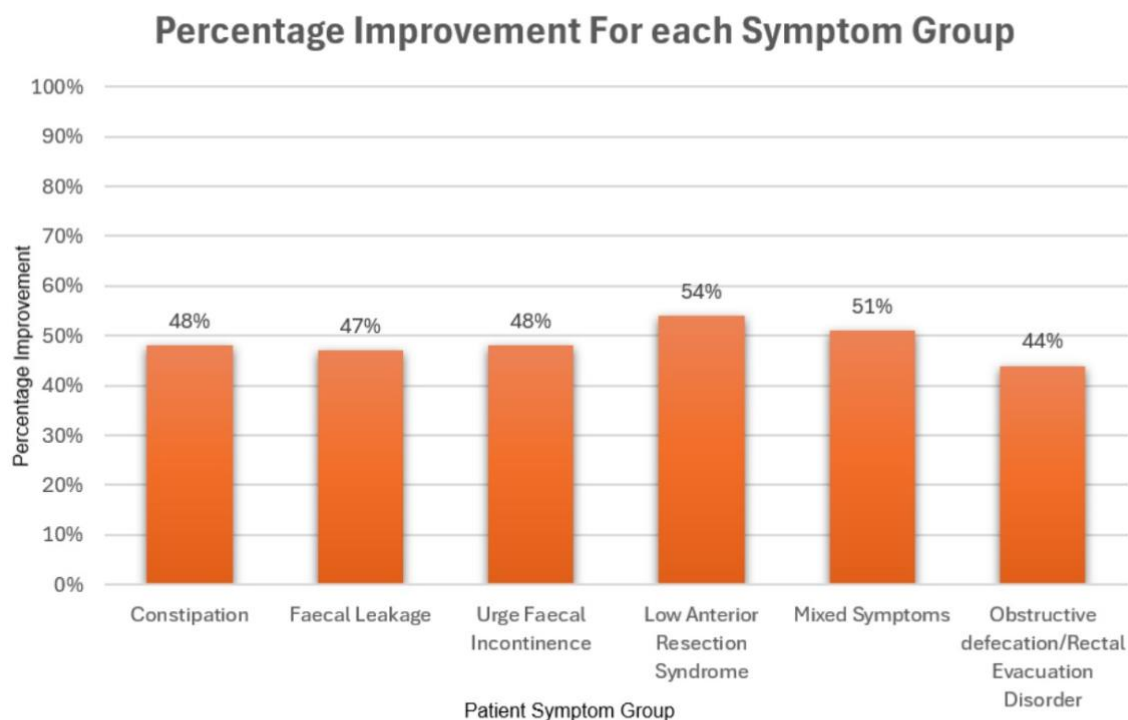


Figure 1: This graph illustrates the six symptom groups present in this review, along with their associated percentage improvement after three months of irrigation use.

Figure 2

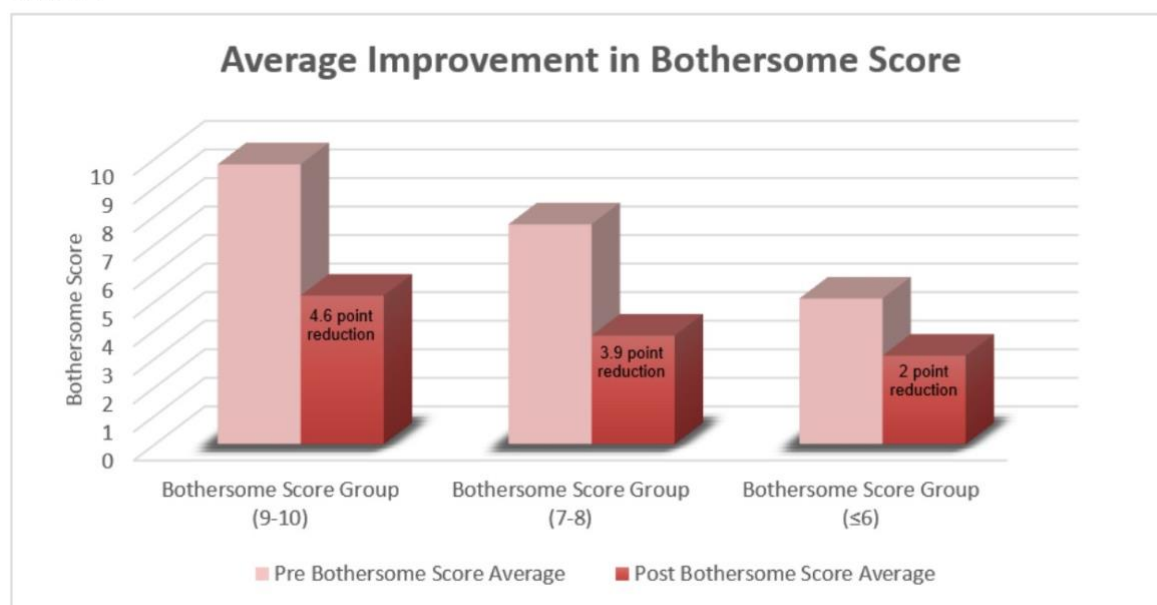


Figure 2: Patients were grouped into three clusters depending on their initial bothersome score. The average score of each group was reviewed again at three months and the decline in bothersome is displayed on this figure.

Real-World Pilot Study Assessing Intermittent Colonic Exoperistalsis (ICE) Treatment with a Novel Medical Device in Adults with Chronic Constipation

Presenting author: Tatenda Marunda (Nurse / allied health professional)

Institution: St Mark's Hospital, The National Bowel Hospital, London

Co-authors: A.D. Brophy¹, P. Dumarán¹, A. Rosa-D'Mello¹, X. Tang¹, C. Vaizey², I. Herrero-Fresneda³, G.P. Thomas¹

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Introduction

Chronic constipation (CC) negatively impacts quality of life (QoL) and may place a significant burden on healthcare services. Intermittent colonic exoperistalsis (ICE) delivered by a novel medical device externally applying sequential pressure alongside the colon, is a non-invasive, home-based therapy designed to support bowel management and patient self-care.

Methods

Adults with CC not responding to conservative treatment were offered either ICE or TAI at screening. Participants who chose ICE were trained and instructed to use the device at home for 20min/day over 12 weeks. Patient-reported outcomes including QoL, constipation symptoms, and additional healthcare utilisation were collected at baseline and at follow-up using validated questionnaires. Health care professionals (HCP) completed structured feedback on the device training and usability burden for each patient.

Results

Data for the first 14 patients completing follow-up. All patients chose ICE over TAI. Adherence was high, with 93% using the device as recommended, and 86% expressing a desire to continue treatment beyond the study period. Patients reported clinically meaningful improvements in bowel management, QoL, and symptom burden, with fewer healthcare resource uses (Table 1). HCP reported the ICE device was easy to manage, required minimal training, and could often be introduced remotely by telephone (Table 2), with 93% of patients improving symptoms.

Conclusion

This early data suggests that ICE is a feasible, scalable, and patient-accepted option for adults with CC. Further work is needed to investigate its effectiveness and position in the treatment pathway for those affected by CC.

Understanding Regret After Delorme's Procedure: Postoperative Outcomes, Predictors, and Patient-Reported Outcomes

Presenting author: Wai Miu Emma Liu (Undergraduate medical student)

Institution: King's College London

Co-authors: Tanzeela Gala², Amy Silver, Linda Ferrari², Alexis Schizas², Alison Hainsworth²

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Introduction

The Delorme's procedure is a perineal repair for full-thickness rectal prolapse (FTRP), commonly for frail patients with significant comorbidity. We investigated surgical, patient-reported outcomes of Delorme's procedure and postoperative patient regret.

Methods

Patients undergoing a Delorme's procedure for FTRP from 2014-2025 were included. Baseline characteristics, operative details and postoperative symptoms (faecal incontinence (FI) and incomplete emptying) were collected. The Ottawa Decision Regret Scale (ODRS) measured regret in three categories: no, mild, or moderate-to-severe.

Results

Twenty-two patients were analysed. Mean age was 71.6. Eight (36.4%) had a prior rectal prolapse repair. 81.8% had low take-off rectal prolapse while the remaining had had high take-off. Concomitant rectocele was reported in 13.6% and enterocele in 18.2% patients. Median follow-up was 51 months. 9.1% patients had a recurrence of prolapse. Postoperatively, 36.4% reported FI, and 22.7% reported incomplete emptying.

Thirteen patients (59.1%) completed the ODRS. Regret was reported by 61.5% patients (53.8% mild, 7.7% moderate-to-severe). Postoperative quality of life improvement (QOL) was reported by 84.6%, while 15.4% stated that it remained the same. No link was found between regret or regret severity and baseline variables or postoperative symptoms. Association between regret levels and recurrence was not analysed due to the small sample size.

Conclusion

Delorme's procedure had a low recurrence rate, but a high proportion had postoperative FI. Patient-reported outcomes showed high postoperative regret rate, but 84% reported QoL improvement. Future qualitative work is required to understand reasons behind regret and the perceived QoL improvement to better aid with shared decision-making when considering the rectal prolapse management.

Figures and tables

Table 1. Association of regret presence with baseline characteristics or postoperative outcomes

Characteristic	No Regret	Regret	<i>p</i> -value
Age, Median (IQR)	80 years (69.8 – 82.8)		1.000
Take off			
High	1 (25.0%)	3 (75.0%)	
Low	4 (44.4%)	5 (55.6%)	1.000
Rectocele			
Y	1 (50.0%)	1 (50.0%)	
N	4 (36.4%)	7 (63.6%)	1.000
Enterocele			
Y	1 (33.3%)	2 (66.7%)	
N	4 (40.0%)	6 (60.0%)	1.000
Recurrent rectal prolapse			
Y	2 (40.0%)	3 (60.0%)	
N	3 (37.5%)	5 (62.5%)	1.000
Post-op faecal incontinence			
Y			
N	3 (60.0%)	2 (40.0%)	
	2 (25.0%)	6 (75.0%)	0.293
Post-op incomplete emptying			
Y			
N	2 (66.7%)	1 (33.3%)	
	3 (30.0%)	7 (70.0%)	0.511
Postoperative recurrence			
Y	1 (50.0%)	1 (50.0%)	
N	4 (36.4%)	7 (63.6%)	1.000
Follow up period, Median (IQR)	51 months (13.8-69.0)		0.685

Table 2. Association of regret severity with baseline characteristics or postoperative outcomes

Characteristic	No Regret	Mild Regret	Moderate to severe regret	<i>p</i> -value
Age, Median (IQR)	80 years (69.8 – 82.8)			0.860
Take off				
High	1 (25.0%)	2 (50.0%)	1 (25.0%)	0.462
Low	4 (44.4%)	5 (55.6%)	0	
Rectocele				
Y	1 (50.0%)	1 (50.0%)	0	0.880
N	4 (36.4%)	6 (54.5%)	1 (9.1%)	
Enterocoele				
Y	1 (33.3%)	1 (33.3%)	1 (33.3%)	0.523
N	4 (40.0%)	6 (60.0%)	0	
Recurrent rectal prolapse				
Y	2 (40.0%)	3 (60.0%)	0	0.709
N	3 (37.5%)	4 (50.0%)	1 (12.5%)	
Post-op faecal incontinence				
Y				0.728
N	3 (60.0%)	2 (40.0%)	0	
	2 (25.0%)	5 (62.5%)	1 (12.5%)	
Post-op incomplete emptying				
Y				0.633
N	2 (66.7%)	1 (33.3%)	0	
	3 (30.0%)	6 (60.0%)	1 (10.0%)	
Follow up period, Median (IQR)	51 months (13.8-69.0)			0.638

“It Changed My Life, or It Was Too Much”: A Patient Centred Account of the Rectal Irrigation Pathway

Presenting author: Wai Miu Emma Liu (Undergraduate medical student)

Institution: King's College London

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Introduction

Rectal irrigation is an established management option for constipation and faecal incontinence when conservative measures fail. However, the patient journey through awareness, initiation, adaptation, routine and outcome have not been explored. We explored lived experience of the irrigation pathway to identify practical, emotional and service level factors shaping uptake, sustained use and quality of life.

Methods

Semi-structured group interviews with purposive sampling to capture diversity in age, gender, ethnicity and socioeconomic status. Participants were current, former or declined users of rectal irrigation. Groups of up to four met. Sessions were recorded, transcribed verbatim and analysed until thematic saturation. Data were synthesised into thematic domains and illustrated with verbatim quotations from transcripts.

Results

Six interviews with 23 participants were conducted. Participants described a coherent multi-stage journey: low initial awareness, specialist-led introduction, and an early learning curve determining whether irrigation became routine. Supervised practice reduced fear, but was considered insufficient without follow-up and reliable supply pathways. Low-volume systems were preferred for portability; high-volume demanded more setup and cleaning. Leakage, disconnection and pumping effort limited independence. Privacy concerns drove concealment, limiting peer support. Administrative failures such as missed renewals interrupted treatment, whilst outcomes ranged from clear symptoms relief to limited benefit.

Conclusion

The journey is shaped by clinical education and follow-up, device ergonomics and reliability, social-emotional context, and ultimately by experienced outcomes. Structured hands-on training, personalised device selection, contact for supplies and troubleshooting, and discreet packing could reduce discontinuation. Coordinated pathways addressing these domains are needed to improve adherence and quality of life for rectal irrigation users.

Figures and tables

Table 1. Patient verbatim responses and themes

Themes	Verbatim response
Clinical Education and Follow Up	
Fragmented continuity of care	"My prescription ran out twice because nobody chased it."
Limited primary care engagement	"They were very dismissive... drink more water, drink some olive oil."
Risk perception and competence gap	"Yeah, I was concerned about long-term use and any possible damage through regular daily use."
Awareness and knowledge gap: low prior awareness of irrigation	"I knew nothing about it."
Specialist unfamiliarity with irrigation	"I said I am doing all this... he literally moved on and didn't ask me any questions."
Device ergonomics and technical reliability	
Device volume shapes acceptability	"Low volume definitely, because it's not such a cumbersome piece of equipment." "The high volume takes me much longer than the low volume."
Managing irrigation outside the home	"It felt quite embarrassing when I had to perform irrigation, as there was only 1 bathroom and lots of people around. Performing irrigation used to give me wind as well, which could be quite loud."
Technical issues: manual effort and ergonomics	"Because I can't stand very long, it's very hard to insert the catheter."
Technical issues: leakage and unpredictability	"A couple of times I've had a little bit of a leak afterwards... it was really awkward once because it happened when I was staying at my mum's over Christmas."
Social-Emotional Context	
Privacy, stigma and selective disclosure	"When I was staying at my mum's, I kept it in a bag... because the tubes are wet, I sort of have to leave them out to dry. And then I'm worried that people would see it."
Clinical Outcomes	
Restored control and life restoration	"It changed my life. I've been so much more free, more relaxed and feel more normal."

Barriers to Rectal Irrigation: A Patient-Centred Qualitative Study of Practical, Emotional and Social Challenges

Presenting author: Tanzeela Gala (Surgical / medical trainee)

Institution: Guy's and St Thomas' NHS Foundation Trust

Co-authors: Tanzeela Gala¹, Seng Yeoh², Emma Liu², Abigail Fernandes¹, Sarah Ferdinand¹, Alexis Schizas¹, Linda Ferrari¹, Alison Hainsworth¹

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Introduction

NICE recommends rectal irrigation for constipation and faecal incontinence refractory to conservative measures, yet uptake and sustained use vary. Non-clinical barriers such as stigma, limited awareness, usability issues and logistical constraints remain insufficiently understood. This study explored patient-centred barriers to rectal irrigation to inform service improvements that support adherence and quality of life.

Methods

We conducted a qualitative study using semi-structured focus groups at a tertiary pelvic floor unit. Adults with defaecatory difficulties who had failed nurse-led biofeedback and were current, former or declined users of rectal irrigation were eligible. Purposive sampling ensured demographic diversity. Sessions were recorded, transcribed verbatim and inductively analysed until thematic saturation was reached.

Results

Six sessions with 23 participants identified six interconnected themes. Risk perception and a competence gap created anxiety about harm, technique and bodily responses, with patients seeking supervised practice. Routine integration varied: some incorporated irrigation into daily life, while others found high-volume systems time-consuming. Usability challenges, including poor ergonomics, pain, leakage and device detachment, caused discomfort and embarrassment. Privacy concerns and stigma led to equipment concealment and selective disclosure. Using irrigation outside the home was difficult due to bathroom constraints and device bulk, prompting avoidance of travel or work use. Awareness before specialist referral was low.

Conclusion

Rectal irrigation is experienced as a complex intervention shaped by emotional, practical and social factors. Addressing competence gaps, usability needs, logistical barriers and stigma is essential to improve uptake and sustained use.

Figures and tables

Table I: Verbatim patient quotations mapped to barrier themes for rectal irrigation

Barrier theme	Verbatim patient comment(s)
Fitting into daily routine	'I thought time was a factor, so I had to get up earlier, because it wasn't always instant with me. Sometimes it would be half an hour later or quarter of an hour later, and then suddenly I had to rush to the loo. So, if I was having to go to work or out somewhere, I would have to wake up super early to do it.'
Early risk perception and fears	'I have never introduced water into my rectum before. I was concerned that maybe I could cause damage to my bowel. I didn't know whether I might perforate it if I put too much in.'
Limited knowledge & awareness	'I mean nothing at all; it was a surprise when I was given information about it.'
Irrigation away from home	'I wouldn't want to carry that bag to the toilet. People might think, why is she taking the bag into the toilet? What's in her bag?'
Privacy, stigma, embarrassment and selective disclosure	'It felt quite embarrassing when I had to perform irrigation, as there was only one bathroom and lots of people around. Performing irrigation used to give me wind as well, which could be quite loud.'
Device ergonomics & technical challenges	'I didn't use it every day because of the complications; there was just too much against it, like leaking onto the floor, splashing all over me, around the toilet seat, and even up the wall sometimes, so it always turned into a clean-up operation.'

“Real World Irrigation”: How Patients Share Rectal Irrigation Experiences on TikTok

Presenting author: Tanzeela Gala (Surgical / medical trainee)

Institution: Guy's and St Thomas' NHS Foundation Trust

Co-authors: Tanzeela Gala¹, Wai Miu Emma Liu², Aveen Hamawandi¹, Yousra Abualnaja¹, Linda Ferrari¹, Alexis Schizas¹, Alison Hainsworth¹

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Introduction

Rectal irrigation (RI) is an effective management tool for bowel dysfunction, yet many patients face stigma, uncertainty, and limited guidance. TikTok, as a video platform, offers an accessible space where users share personal experiences that may support awareness, education, and adherence. We analysed TikTok content on RI to understand user experiences and identify informational gaps.

Methods

Hashtags linked to RI were searched, and the first 100 videos per hashtag were screened by two independent reviewers. English language videos by unique users on RI were included. Data on user demographics, engagement, device type, and content characteristics were collected. Thematic analysis identified recurring themes.

Results

Across six hashtags, 1,079 videos were identified, and 123 met eligibility criteria. These represented 21 unique creators, all of whom were patients using irrigation. Twelve creators (58%) posted multiple irrigation-related videos, and 90% of those videos featured high-volume systems. Videos averaged 152 seconds and generated a mean of 2,592 likes, 81.8 shares, and 39 comments. Three themes emerged. Practical instruction and device-navigation were most common, with creators demonstrating equipment, outlining steps, and referencing manufacturers. Clinical purpose and perceived effectiveness captured reasons for adopting irrigation and reported symptom improvement. Psychosocial and quality-of-life narratives highlighted efforts to reduce stigma, normalise irrigation, and describe its impact on daily life while offering encouragement to viewers.

Conclusion

TikTok content on rectal irrigation focuses on practical guidance and normalisation but offers limited troubleshooting, device comparison, or structured help seeking information. These gaps highlight the need for clearer, evidence-based digital education and opportunities for clinicians to engage with patients online.

Figures and tables

Figure 1. Screening and Inclusion Flowchart for TikTok Videos on Rectal Irrigation

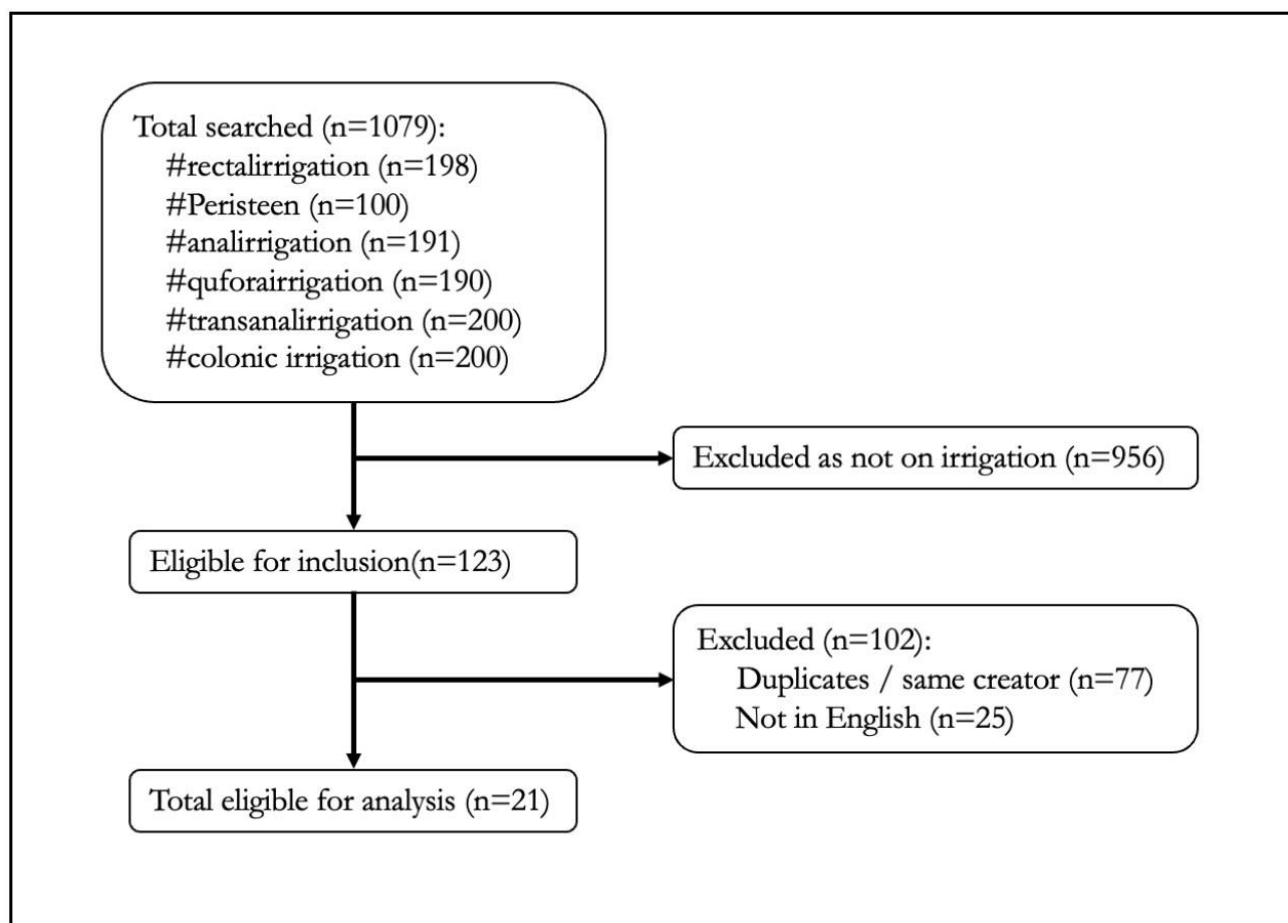


Table 1. Themes addressed in TikTok videos

Thematic categories	Number (n=21)
Practical Instruction and Device Navigation	
Explaining/showing irrigation equipment	20/21 (95%)
Performing irrigation	13/21 (62%)
Technical difficulties	2/21 (10%)
Mentioning manufacturers	19/21 (91%)
Comparing equipment	1/21 (5%)
Knowledge of different systems	2/21 (10%)
Clinical Purpose and Perceived Effectiveness	
Explaining the reasons why people use irrigation	17/21 (81%)
Outcome of irrigation on symptoms	7/21 (33%)
Psychosocial and Quality-of-Life Narratives	
Impact of irrigation on QoL	7/21 (33%)
Breaking taboo	8/21 (38.1%)
Offering help to viewers	6/21 (28.6%)

Differential Predictors of Regret in Younger vs Older Adults Undergoing Ventral Mesh Rectopexy: a 10-year Retrospective Cohort Analysis

Presenting author: Tanzeela Gala (Surgical / medical trainee)

Institution: Guy's and St Thomas' NHS Foundation Trust

Co-authors: Amy Silver¹, Wai Miu Emma Liu², Tanzeela Gala¹, Linda Ferrari¹, Alexis Schizas¹, Alison Hainsworth¹

Introduction

Ventral mesh rectopexy (VMR) is an accepted technique for full-thickness rectal prolapse (FTRP) repair, yet data on patient regret are limited. This study evaluated regret after VMR for FTRP, including outcomes and age-related differences.

Methods

Patients undergoing VMR for FTRP from 2014–2025 were included. Baseline data, postoperative faecal incontinence (FI), incomplete emptying (IE), and recurrence were recorded. Regret was assessed using the Ottawa Decision Regret Scale and compared between patients <70 and ≥70 years.

Results

Eighty patients were included; 75 (94%) were female, mean age 59.7 years, median follow up 42.5 months. Recurrence occurred in 12 (15%), FI in 33 (41%), and IE in 54 (68%). Overall, 49 (61%) reported no regret, while 31 (39%) reported regret (mild 23%, moderate to severe 18%). Recurrence was strongly associated with regret ($p < .0001$).

Fifty seven patients were <70 years and 23 ≥70 years. In younger patients, recurrence occurred in 6 (11%), FI in 25 (44%), and IE in 44 (77%). In older patients, recurrence occurred in 6 (26%), FI in 8 (35%), and IE in 10 (44%). IE was significantly more common in younger adults ($p = .004$). Regret was also higher in younger patients (46% vs 22%, $p = .047$). Predictors of regret differed by age. In <70 patients, recurrence was the strongest driver of regret ($p = .005$) and severity ($p = .009$). In ≥70 patients, FI was more strongly associated with regret ($p = .016$) and severity ($p = .033$).

Conclusion

Regret after VMR depends on patients age, highlighting need for age-specific, outcome-focused counselling. Further qualitative research is crucial to better understand the drivers of regret.

Figures and tables

Table 1 Association between postoperative symptoms or recurrence and surgery type with presence of regret

	Age <70 (n=57)		OR	p-value ^a	Age ≥70 (n=23)		OR	p-value ^a
	No Regret	Regret			No Regret	Regret		
Overall	31 (54.4%)	26 (45.6%)	-	-	18 (78.3%)	5 (21.7%)	-	0.047
Recurrence								
Y	0	6 (100%)			3 (50.0%)	3 (50.0%)		
N	31 (60.8%)	20 (39.2%)	1.3 (1.05-1.61)	0.005	15 (88.2%)	2 (11.8%)	7.50 (0.85-66.1)	0.051
Postoperative Symptoms								
Faecal incontinence								
Y	13 (52.0%)	12 (48.0%)			4 (50.0%)	4 (50.0%)		
N	18 (56.3%)	14 (43.8%)	1.19 (0.42-3.39)	0.749	14 (93.3%)	1 (6.7%)	14.0 (1.20-163.3)	0.016
Incomplete emptying								
Y	24 (54.5%)	20 (45.5%)			8 (80.0%)	2 (20.0%)		
N	7 (53.8%)	6 (46.2%)	0.97 (0.28-3.36)	0.965	10 (76.9%)	3 (23.1%)	0.83 (0.11-6.26)	0.859

^a p-value from two-sided Pearson Chi-Square

Table 2 Association between postoperative symptoms or recurrence and surgery type with regret severity groups

	Age <70 (n=57)			p-value ^a	Age ≥70 (n=23)			p-value ^a
	No Regret	Mild Regret	Moderate to severe regret		No Regret	Mild Regret	Moderate to severe regret	
Overall	31 (54.4%)	13 (22.8%)	13 (22.8%)	-	18 (78.3%)	4 (17.4%)	1 (4.3%)	0.084
Recurrence								
Y	0	3 (50.0%)	3 (50.0%)		3 (50.0%)	2 (33.3%)	1 (16.7%)	
N	31 (60.8%)	10 (19.6%)	10 (19.6%)	0.009	15 (88.2%)	2 (11.8%)	0	0.089
Postoperative Symptoms								
Faecal incontinence								
Y	13 (52.0%)	4 (16.0%)	8 (32.0%)		4 (50.0%)	3 (37.5%)	1 (12.5%)	
N	18 (56.3%)	9 (28.1%)	5 (15.6%)	0.328	14 (93.3%)	1 (6.7%)	0	0.033
Incomplete emptying								
Y	24 (54.5%)	9 (20.5%)	11 (25.0%)		8 (80.0%)	1 (10.0%)	1 (10.0%)	
N	7 (53.8%)	4 (30.8%)	2 (15.4%)	0.645	10 (76.9%)	3 (23.1%)	0	0.394

^a p-value from two-sided Pearson Chi-Square

Recurrence and complications after ventral mesh rectopexy: a single-centre retrospective cohort study

Presenting author: Sophia Moschkau (Surgical / medical trainee)

Institution: Northumbria Healthcare NHS Foundation Trust

Co-authors: Sabry Abounoza², Christopher Emmett¹, Benjamin Box¹

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Aim

To evaluate recurrence following ventral mesh rectopexy (VMR), comparing outcomes by mesh type and surgical approach.

Methods

A retrospective cohort study of 224 patients undergoing VMR within Northumbria Healthcare NHS Trust between 2008 and 2025 was performed. Data included demographics, indication, surgical approach (robotic-assisted vs laparoscopic), mesh type and recurrence. Recurrence rates were compared using Fisher's exact test. Kaplan–Meier analysis with log-rank testing accounted for differences in follow-up. Post-operative complications and 90-day mortality were recorded.

Results

Synthetic mesh had lower crude recurrence than Permacol (0% vs 22.8%; Fisher's exact $p=0.010$). This difference remained significant on Kaplan–Meier analysis (log-rank $p=0.008$). Robotic-assisted VMR had lower crude recurrence than laparoscopic surgery (10.3% vs 22.8%; Fisher's exact $p=0.085$), but this difference was not significant on Kaplan–Meier analysis (log-rank $p=0.846$). Median follow-up was shorter for robotic than laparoscopic VMR (2.2 vs 7.0 years). Two deaths occurred within 90 days. Four post-operative complications were recorded: three small bowel injuries and one return to theatre for disimpaction of rectum.

Conclusion

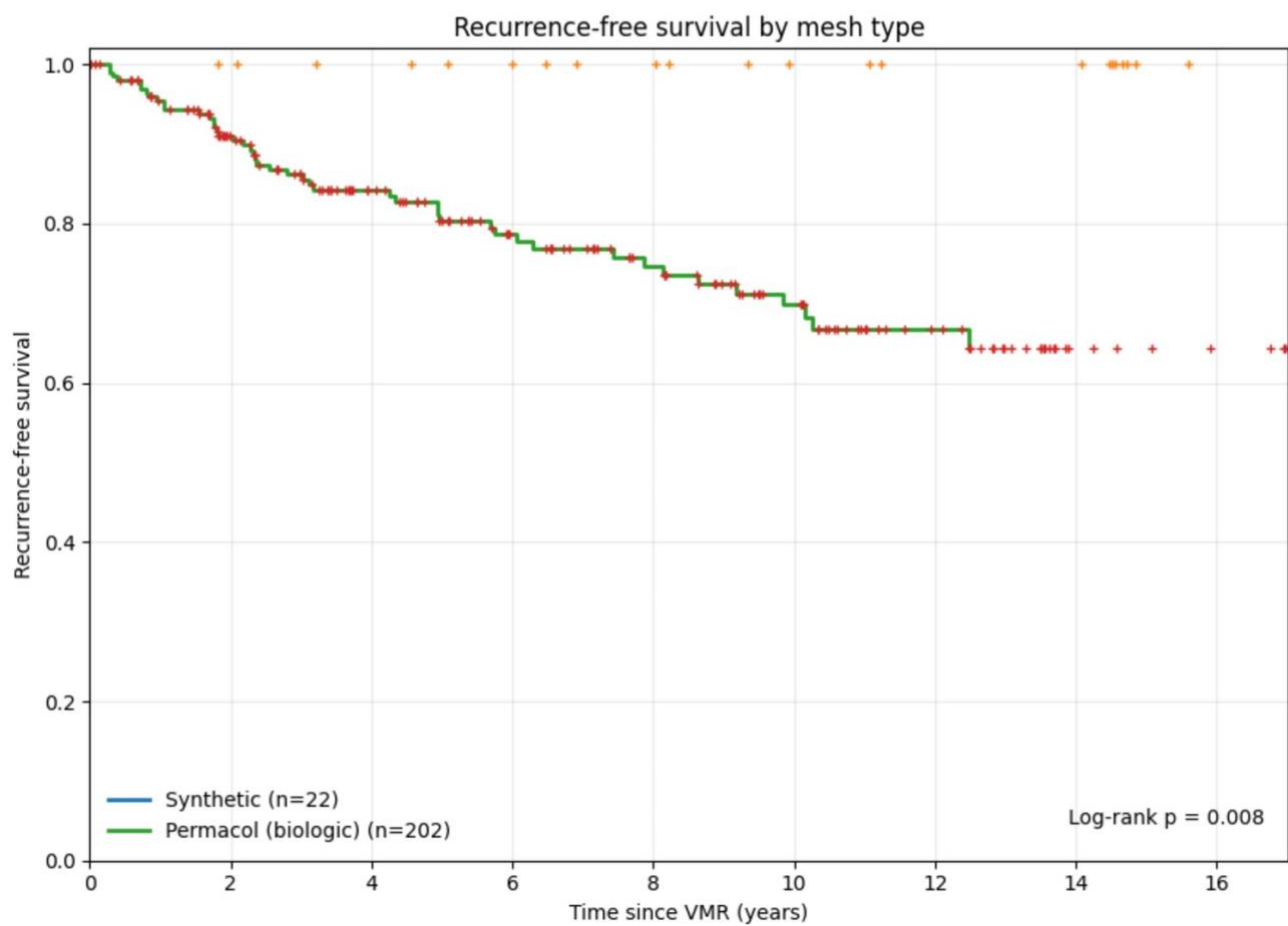
Synthetic mesh was associated with lower recurrence than Permacol, with this association persisting after accounting for follow-up. Although robotic VMR had lower crude recurrence, this difference was not observed on time-to-event analysis. The shorter follow-up in the robotic cohort highlights the importance of accounting for follow-up duration when comparing recurrence following VMR.

Figures and tables

Cohort	Recurrence	No recurrence	Total	Recurrence rate
Synthetic mesh	0	22	22	0%
Biologic mesh	46	156	202	22.8%
Robotic-assisted*	4	35	39	10.3%
Laparoscopic*	42	142	184	22.8

Overall cohort 224 patients, 46 recurrences (20.5%)

*One patient underwent laparotomy and was excluded from the robotic/laparoscopic comparison.



Suture versus Taker Rectopexy for Young Male Rectal Prolapse: A Retrospective Analysis of Recurrence and Perioperative Outcomes

Presenting author: Ammar Aleter (Surgical / medical trainee)

Institution: Hamad Medical Corporation

Co-authors: Ammar Aleter¹, Ahmed Hwafdh¹, Salwa Awad¹, Ali Toffaha¹, Noof Alnaimi¹, Mohammed Abunada¹, Amjad Parvaiz^{1,2}

¹Hamad Medical Corporation, Doha, Qatar

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Background

Rectal prolapse is a debilitating condition, classically affecting elderly women, for which surgical rectopexy is the definitive treatment. Surprisingly, some populations have a rare predominance of young males over females with rectal prolapse. A few studies have discussed management in young males. Whether suture or tucker fixation gives more durable results remains debated. We report a consecutive of rectopexy procedures and compare recurrence by technique.

Methods

We retrospectively reviewed 25 consecutive patients over five years who underwent surgery for rectal prolapse. Demographic, operative, and follow-up data were extracted and analyzed descriptively. Recurrence (a documented date of recurrence) was compared between suture and tucker rectopexy.

Results

Mean age was 38.8 ± 9.4 years and 87.5% of patients were male, an inverted sex ratio compared with most published series. Laparoscopic rectopexy was performed in 72% of patients, and Altemeier's perineal rectosigmoidectomy in 16%, mostly for emergency presentations. No 30-day complications were documented. Overall recurrence was 24% (6/25) at a median of 14.0 months. Recurrence was markedly more frequent after tucker rectopexy (5/11, 45.5%) than after suture rectopexy (1/9, 11.1%; 0/7 within the laparoscopic subgroup).

Conclusion

In this predominantly young and male cohort, posterior suture rectopexy was associated with a numerically lower recurrence rate than tucker rectopexy. No statistically significant sexual dysfunction or incontinence was encountered. A proper posterior rectal dissection upto pelvic sphincter was a key component in suitable fixation of the rectum and preventing recurrence.

Impact of Levatorplasty on Recurrence Following Altemeier's and Delorme's Procedures: Systematic Review and Meta-Analysis

Presenting author: Praveen Sekaran (Surgical / medical trainee)

Institution: Basildon University Hospital, Mid and South Essex NHS Trust

Co-authors: Manisha Soul¹, Kirsty McDowell¹

¹Basildon University Hospital, Mid and South Essex NHS Trust

Introduction

Rectal prolapse is circumferential prolapse of rectal mucosa through the anal canal, increasingly common with an aging population and age-related muscle weakening. Perineal procedures are often preferred for their minimal invasiveness and avoidance of general anaesthesia. Levatorplasty, narrowing of the levator hiatus with sutures, has been added to reduce recurrence, but its benefit remains unclear.

Methods

PubMed, MEDLINE, Clinical Trials, and Embase were searched from inception to July 2026, following PRISMA guidelines (PROSPERO CRD420261432001). Studies comparing recurrence after Delorme's or Altemeier's procedures, with and without levatorplasty, were included; non-English, paediatric, and abdominal-only studies were excluded. Primary outcome was full-thickness recurrence. Two reviewers independently extracted data and assessed risk of bias (RoB-2, Newcastle-Ottawa). A random-effects meta-analysis using odds ratios was performed in JASP; $I^2 > 50\%$ denoted considerable heterogeneity.

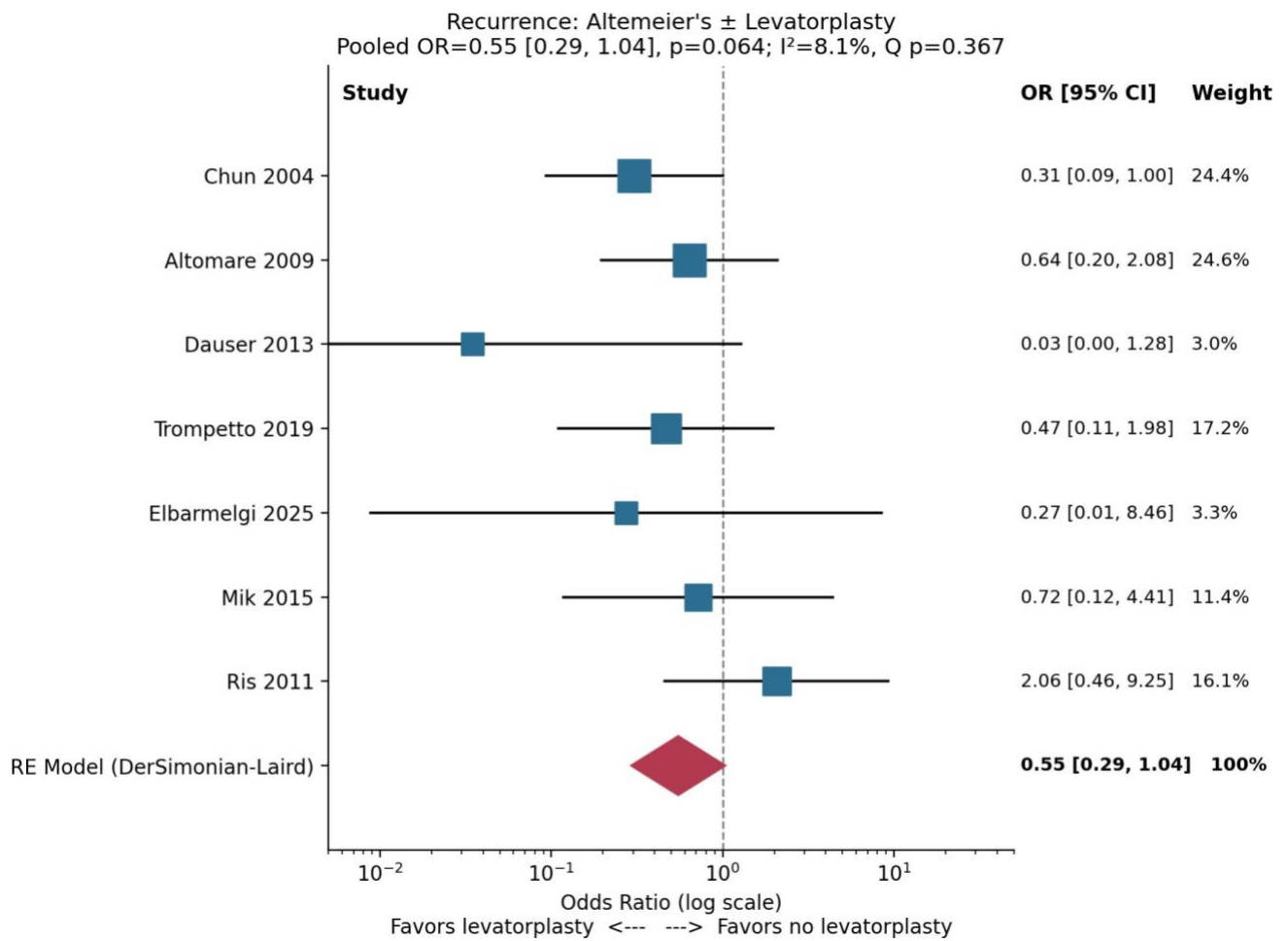
Results

Of 234 studies identified, 11 met inclusion criteria; 10 provided data for quantitative synthesis (one compared levatorplasty alone versus levatorplasty with an additional procedure, and was excluded from pooling). Eight studies (420 patients; 221 with levatorplasty) addressed Altemeier's, and two (124 patients; 48 with levatorplasty) addressed Delorme's. Among Altemeier's studies, levatorplasty was associated with significantly lower odds of recurrence (pooled OR 0.54, 95% CI 0.30–0.95, $p=0.033$), with no heterogeneity ($I^2=0.0\%$). Delorme's data showed a similar directional trend but were too few to formally pool.

Conclusion

Levatorplasty significantly reduces recurrence when added to Altemeier's procedure, a finding robust on sensitivity analysis. Evidence for Delorme's is promising but preliminary. Larger prospective studies, particularly for Delorme's, are needed to confirm these findings.

Figures and tables



Does the NHS Bristol Royal Infirmary Rectal Prolapse service meet the NHS England 18-Week RTT Standard? A Baseline Audit

Presenting author: William Strachan (Surgical / medical trainee)

Institution: Bristol Royal Infirmary, Bristol

Co-authors: Rebecca Griggs¹, Jonathan Randall¹

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Introduction

Rectal prolapse is a distressing and debilitating condition that usually requires surgical management. The treatment pathway at Bristol Royal Infirmary (NHS Bristol Foundation Trust) is multistep and multi-disciplinary. NHS England's 2025 Elective Reform Plan requires $\geq 92\%$ compliance with the 18-week referral-to-treatment (RTT) standard. Assessing compliance to the standard and identifying pathway delays facilitates service improvement.

Methods

Retrospective audit of all elective rectal prolapse cases over 24 months from operating lists. 43 cases were identified of which 14 were excluded, leaving 29 full elective referral pathway cases. Documentation was used to construct individual and service level pathway maps. Referral-to-clinic and surgery intervals were measured against the 18-week RTT standard.

Results

38% (11 of 29) of patients were seen in clinic within 18 weeks, and only 3.4% (1 of 29) underwent surgery within the full-clock 18-week target, against the 92% standard. Referral to first clinic appointment took a median of 231 days; listing to surgery took 148 days; and the overall referral-to-surgery interval took 585 days. GP referrals were the largest (38%) and slowest route (median 294 days). 4 patients were incorrectly routed to non-specialist clinics and 86% of patients reached a pelvic floor specialist at first contact.

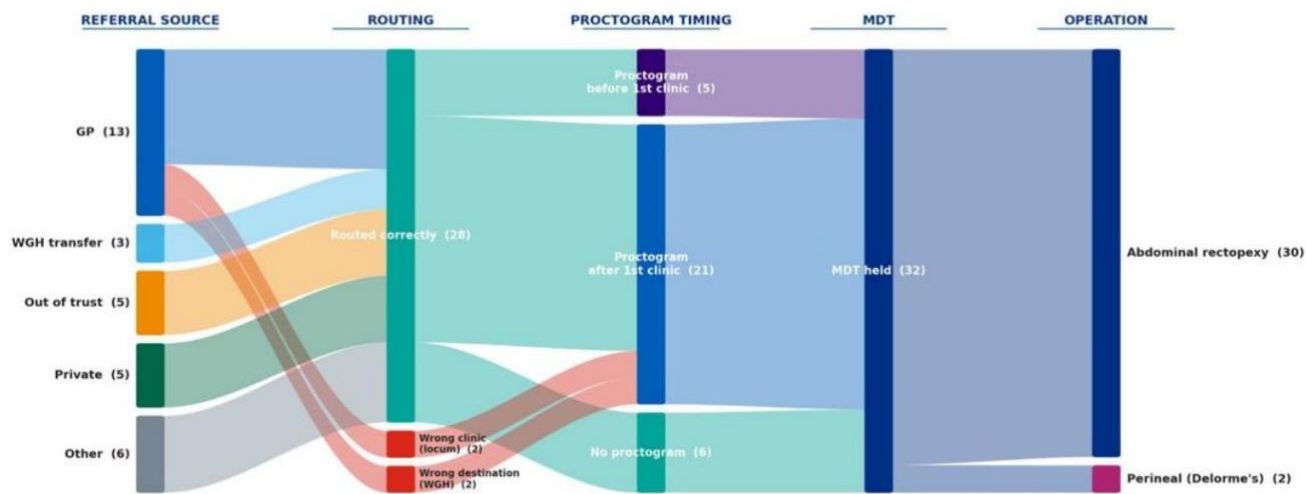
Conclusion

The elective rectal prolapse pathway at UHBW does not currently meet the 92% RTT standard. The predominant delay is between referral and first clinic, most significant for GP referrals. A minority of breaches are avoidable, caused by misrouting to non-specialist clinics. Our recommendation is prioritisation of rectal prolapse patients to clinic amongst all benign referrals.

Figures and tables

Patient flow — referral, routing, proctogram timing, MDT and operation

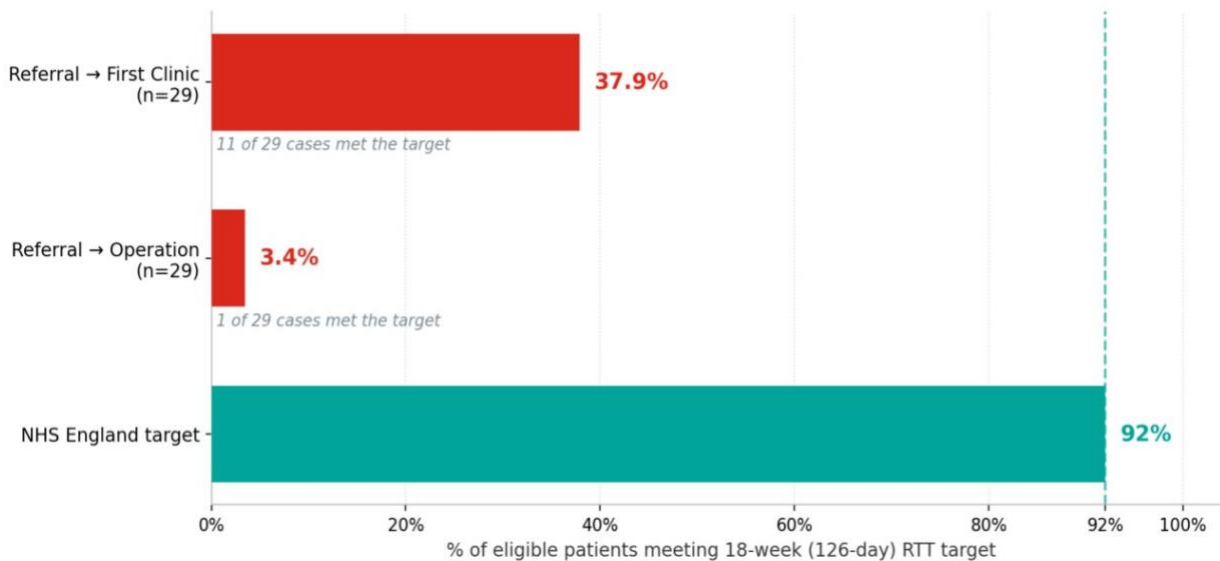
n = 32 elective non-IBD cases



Red bands = routing failures (wrong clinic at BRI, or wrongly sent to WGH first). 'Other' = 2WW (1), Internal BRI (1), Physiology (1), Already known (1), Relapse (2).

Abdominal rectopexy (n=30): Laparoscopic VMR (16), Robotic VMR (11), Robotic Suture (2), Lap Posterior Suture (1). Perineal: Delorme's (2) — performed for frail patients.

18-week RTT compliance vs NHS England 92% target



Robot-assisted apical pelvic floor reconstruction with selective mesh use: early outcomes from a UK tertiary centre

Presenting author: Hara Koukouli (Surgical / medical trainee)

Institution: University College London Hospitals NHS Foundation Trust

Co-authors: Wesam Hammouri¹, Arvind Vashisht¹

¹University College London Hospitals NHS Foundation Trust, London

Introduction

This is a retrospective study of the first consecutive cohort undergoing robot-assisted complex apical pelvic floor reconstruction in a tertiary UK centre with expertise in minimal access urogynaecology.

Methods

We report surgical, anatomical and patient-reported outcomes using validated instruments. Descriptive statistics and the Wilcoxon signed-rank test were used.

Results

25 women underwent a robot-assisted procedure for uterine or vault prolapse between October 2023 and October 2025. Reconstruction was promontory-based in 24/25 (96.0%): 10 permanent-suture sacrohysteropexies (40.0%), 12 permanent-suture sacrocolpo/cervicopexies (48.0%) and 2 mesh sacrocolpopexies (8.0%). 19/25 women (76.0%) had a uterus at surgery and 9/25 (36.0%) had a concomitant hysterectomy. A retropubic operation, colposuspension or paravaginal repair, was performed in 9/25 (36.0%). Additional anterior/posterior compartment operations were performed in 14/25 women (56.0%), using robot-assisted or vaginal approaches. Overall, 23/25 women (92.0%) had a mesh-free operation.

All 25 cases were completed without conversion or intraoperative complications. Perioperative complications within 30 days occurred in 6/25 women (24.0%), all Clavien–Dindo grade I–II. There was one readmission.

Postoperative assessment was available for 19/25 women (76.0%) at a median follow-up of 5.6 months (IQR 3.6–8.7). Median point C improved from 0.0 to –6.0 cm and median Ba from +1.5 to –1.0 cm (both $p < 0.001$). On PGI-I, prolapse symptoms were very much or much better in 15/16 women (93.8%). All available paired median ICIQ scores improved.

Conclusion

Predominantly meshless, complex apical pelvic floor reconstruction was feasible and safe within the context of a new robotic programme in a UK tertiary centre with favourable early outcomes.

Robotic suture sacrohysteropexy: representative operative steps

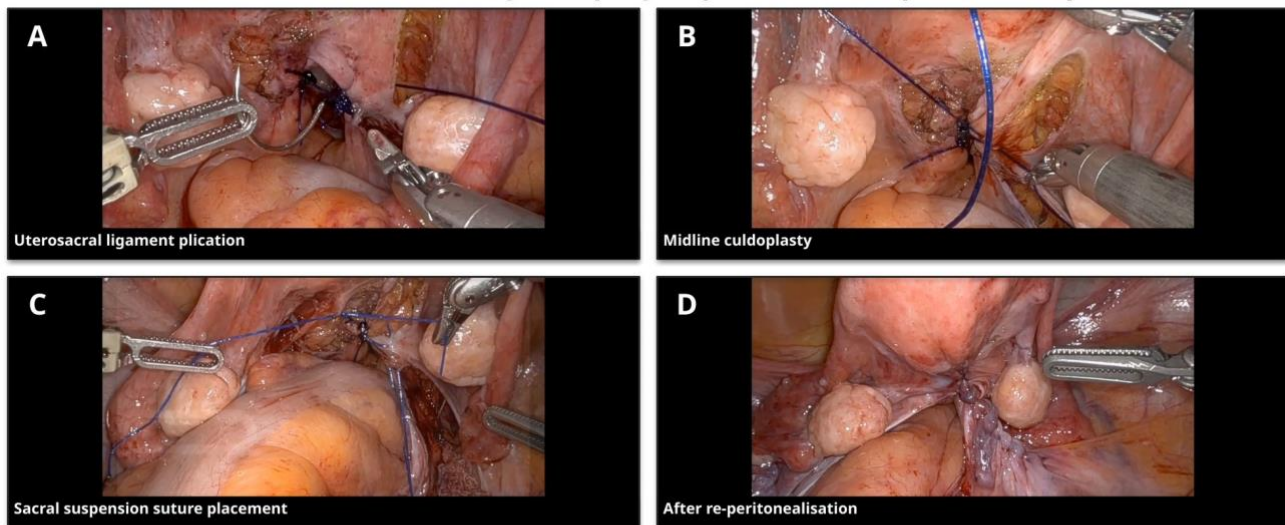


Figure 1. Key operative steps of robotic suture sacrohysteropexy. (A) Individual uterosacral ligament plication. (B) Midline culdoplasty approximating the plicated uterosacral ligaments. (C) Sacral suspension with permanent sutures from the uterine torus to the sacral promontory and back. (D) Appearance after re-peritonealisation covering the permanent suspension sutures.

Table 1. Cohort characteristics, reconstructive profile and early outcomes following robot-assisted apical pelvic floor reconstruction (N=25)

Patient and prolapse characteristics	Result	Early anatomical and patient-reported outcomes ^a	Result
Age, years, mean (SD)	59.6 (11.8)	POP-Q point C, cm (n=18)	0.0 (-2.8 to 2.8) → -6.0 (-7.0 to -5.0); p < 0.001
Body mass index, kg/m ² , mean (SD)	27.7 (4.3)	POP-Q point Ba, cm (n=18)	1.5 (1.0 to 3.0) → -1.0 (-2.0 to 0.0); p < 0.001
Parity/vaginal deliveries, median (IQR)	2 (1-3)	POP-Q point Bp, cm (n=18)	-1.5 (-2.0 to -0.6) → -2.0 (-2.0 to -2.0); p = 0.096
Previous pelvic floor surgery	9/25 (36.0%)	ICIQ-VS vaginal symptoms (n=11)	28.0 (24.5 to 35.5) → 7.0 (2.5 to 14.5); p = 0.004
Uterus present at the start of surgery	19/25 (76.0%)	ICIQ-VS Q14 quality of life (n=11)	8.0 (8.0 to 9.5) → 3.0 (1.5 to 6.0); p = 0.014
Preoperative point C: -5 to -2 cm	8/25 (32.0%)	ICIQ-UI SF (n=11)	10.0 (4.5 to 13.5) → 3.0 (2.0 to 7.0); p = 0.0497
Preoperative point C: -1 to +1 cm	9/25 (36.0%)	PGI-I prolapse: very much or much better ^b	15/16 (93.8%)
Preoperative point C: +2 to +10 cm	8/25 (32.0%)	PGI-I urinary symptoms: very much or much better ^c	9/14 (64.3%)
Primary apical reconstruction	Result		
Permanent-suture sacrohysteropexy	10/25 (40.0%)		
Permanent-suture sacrocolpopexy	11/25 (44.0%)		
Permanent-suture sacrocervicopexy	1/25 (4.0%)		
Mesh sacrocolpopexy	2/25 (8.0%)		
Uterosacral plication and culdoplasty without promontory fixation	1/25 (4.0%)		
Mesh-free apical support	23/25 (92.0%)		
Reconstructive components and concomitant procedures	Result		
Uterosacral ligament plication (any use)	19/25 (76.0%)		
Culdoplasty (any use)	16/25 (64.0%)		
Robot-assisted hysterectomy (8 total; 1 subtotal)	9/25 (36.0%)		
Retropubic (6 Burch colposuspensions; 3 paravaginal repairs)	9/25 (36.0%)		
Any additional anterior/posterior compartment or perineal repair	14/25 (56.0%)		
Robot-assisted anterior repair	4/25 (16.0%)		
Robot-assisted enterocoele/high posterior repair	11/25 (44.0%)		
Vaginal anterior repair	2/25 (8.0%)		
Vaginal posterior repair/perineorrhaphy	4/25 (16.0%)		
Two or three major procedural domains combined ^d	16/25 (64.0%)		
Perioperative outcomes	Result		
Robot-assisted completion without conversion	25/25 (100.0%)		
Intraoperative complications	0/25 (0.0%)		
Complications within 30 days, Clavien-Dindo I-II	6/25 (24.0%)		
Complications within 30 days, Clavien-Dindo III-V	0/25 (0.0%)		
Readmission within 30 days	1/25 (4.0%)		
Estimated blood loss, mL, median (IQR)	50 (50-50)		
Postoperative stay, nights, median (IQR)	2 (1-3)		

Values are n/N (%) unless stated otherwise. Primary apical categories sum to 25; other procedure counts overlap. Plication and culdoplasty totals include the non-promontory case. All abdominal procedures were robot-assisted; vaginal procedures are specified.

^a Major procedural domains: apical reconstruction, hysterectomy and retropubic surgery.

^b Postoperative assessment was documented in 19/25 women (76.0%) at a median follow-up of 5.6 months (IQR 3.6-8.7). Paired results are preoperative → postoperative medians (IQR); n denotes paired observations. p values: Wilcoxon signed-rank test.

^c Two women without urinary symptoms before or after surgery were excluded from the urinary PGI-I denominator. SD, standard deviation; IQR, interquartile range; POP-Q, Pelvic Organ Prolapse Quantification; ICIQ, International Consultation on Incontinence Questionnaire; VS, vaginal symptoms; UI SF, Urinary Incontinence Short Form; PGI-I, Patient Global Impression of Improvement.