Patient Information on STARR

Indications for STARR:

1. Obstructive defaecation syndrome (ODS) is a type of constipation caused by having one or both of the following 'structural changes' in your bowel. (covered by NICE guidance)

- A Collapsed Rectum/internal rectal prolapse or intussusception (IRP) - rather like a telescope or sock that is folding in on itself particularly when emptying your bowels, particularly if it is extending into the anal canal (back passage)
- A Rectocoele or a prolapse of the wall between the rectum and vagina. Like a pocket, stools can be trapped within it when you try to empty your bowels. This can produce feelings of incomplete emptying of the bowel, the need to revisit the toilet and faecal soiling or overt incontinence.

2. High grade haemorrhoids that prolapse when associated with high-grade (IV) IRP

3. High-grade IRP extending to the ano-cutaneous junction (Grade V) i.e visible at the anus to the examining Dr

4. Minor external rectal prolapse in a patient who is unfit for more extensive or longer surgery

5. IRP causing faecal incontinence

6. IRP with early solitary rectal ulcer (SRU)

Symptoms include:

- The need for regular laxatives and/or enemas
- More frequent and/or longer visits to the toilet
- Digitation or the need to put your fingers or thumb in your vagina, perineum or bottom to empty your bowels
- Straining, which can be prolonged and painful
- A feeling of not always having emptied your bowels fully
- Post evacuaton soiling, or faecal incontinence
- Pelvic pain
- Rectal bleeding
- Prolapsed haemorrhoids

What exactly is the STARR procedure?

S.T.A.R.R. is an operation performed under a general or spinal anaesthetic that usually requires an overnight stay in hospital, but can be safely done as a day case.. The procedure involves removing, through your anus, the section of your rectum that contains the prolapse or the intussusception. The two remaining ends are then reconnected using special permanent medical staples made of titanium, which don't set off airport scanners. The procedure can be very painful in the immediate postoperative period such that powerful painkillers will be prescribed.

Benefits?

- Easier and quicker emptying of your bowel and without the need to strain or digitate your rectum, vagina or perineum.
- Cure of faecal incontinence
- Cure of prolapsing haemorrhoids and associated bleeding
- A more regular bowel habit
- Reduced or no need for laxatives
- Much more comfortable rectum, vagina and pelvic floor
- Improved quality of life

Risks?

Some early post-operative pain, bleeding and a bruised perineum are not usual. Whilst this can be associated with a feeling of heaviness it usually settles down very quickly without the need to go to hospital - so don't panic. Persistent bleeding requiring admission and or a transfusion etc is very unusual (<1%). Some patients experience difficulty with passing urine and it may be necessary to pass a catheter into the bladder for a brief period. Post - operative infection is very rare, however any rise in temperature, inflammation, increase in pain or discharge should be reported. Most patients (2/3) will experience a period of postoperative faecal urgency, particularly first thing in the morning. This resolves in 50% of cases within 4 months and in 90% by one year. In patients where it persists or recurs it is likely that you may have a recurrence or persistence of the original prolapse.

Is STARR painful?

Sadly all operations are painful and to combat this your anaesthetist will prescribe you with adequate amounts of analgesisa for the immediate post-operative period - so don't be a heroine ask the nurses! Some surgical teams will pre-empt the pain and prescribe you a pre-med of either gabapentin or amitriptyline. These can make you feel light-headed. If the pain still proves difficult to control, intravenous Ketamine can be very effective. Pain control is important because poor pain control can lead to the development of a central sensitization (chronic pain) in susceptible patients (<1%). Because the procedure itself doesn't involve a cut to the skin, the amount of discomfort is usually minimal and confined to a "smarting" from cracks/splits in your anal skin when you open your bowels; pain-killers, like paracetamol and ibuprofen, are usually sufficient.

Please avoid codeine, tramadol and similar opiates as they not only will constipate you and make things worse but they will also not work! If you are in the small group of patients where pain becomes an issue, don't come up to A&E as you will almost certainly be given some morphine (which wont help) and then sent home again.

What you need is your GP to prescribe you with a course of Gabapentin 600mg tds for 3-4 weeks. Some individuals may also require the addition of a night-time dose of Amitriptyline 10-30mg. These two drugs can make you sleepy so you will need to avoid alcohol, driving and working with machinery.

Diet?

What you eat has a direct impact on your bowel motions and the amount of wind you produce. Try to avoid foods that may constipate you or cause increased wind such as excess fibre.

What about showering afterwards?

Yes and as often as is required. If the skin becomes very sore around your bottom we recommend that you gently wash with warm water and aqueous cream (no soap), gently dry using a hairdryer and then cover the area with a barrier cream e.g., Metanium or Sudocream (nappy cream products purchased from the chemist).

What about work?

Expect to be off work for at least one - two weeks following your surgery. Exercise may be gently introduced after one week; this should be of a low impact type, more physical exercise and riding a bicycle may be gradually introduced from about a month to six weeks onwards.

And sex?

You can start sexual intercourse when you are comfortable. If you are anxious then it is best for the woman to take control by sitting on top of her partner. If any discomfort is felt leave it for a few days before trying again. Due to the close proximity of your operation site, anal intercourse should be avoided for a minimum of six months, and only then with a suitable lubricant and condom.

What will happen to my bowels?

Your new bottom will take a little time to adjust to. Often you might notice the sensation of needing to go to the toilet quickly. This 'urgency' may last several weeks or months although its severity will reduce rapidly. If you had problems with the involuntary passage of wind or stool before your operation, these symptoms may worsen. This is because the prolapse in your back passage has meant you have been emptying your bowels in a different way for some time. If this is the case, you will-need some help to 'retrain' your bowels using the muscles of your pelvic floor. If you have difficulty performing your exercises you can request an appointment with the Pelvic Floor Dysfunction Specialist Nurse for help or to look at other treatment options for improving the strength of these muscles. Rarely this urgency will persist beyond one year and in these patients it is usually because the prolapse is still persisting. LVM Rectopexy is sometimes required in these cases

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