International Journal of Art & Humanity Science (IJAHS) e-ISSN: 2349-5235,
www.ijahs.com Volume 4 Issue 1, (Jan-Feb 2017), PP. 13-15

Giant Complete rectal prolapse: a case report

asedik59@yahoo.com

Alaa Sedik*,Ahmed Fathy,Mufeed Maali,Mahmoud Makhdomi,Abrar Hussein,Salwa ElHoushy+

Department of General Surgery, King Khalid Hospital Hail, Saudi Arabia

+Department of Internal Medicine, King Khalid Hospital Hail, Saudi Arabia

Abstract
Rectal prolapse is an intussusception of the rectum through the anal canal. The extent of the prolapse varies from the rectal mucosa to the full thickness of the rectum and sigmoid colon. It usually appears after 50 years of age, with a female predominance of over 80–90% of cases.

Any condition leading to increased intrabdominal pressure is contributory. This rectal prolapse is always an inconvenience for patient. In his article, we discuss a case of giant rectal prolapse that occurred in a young male patient .

Key words: Anorectal disease, Rectal prolapse, emergency, surgery

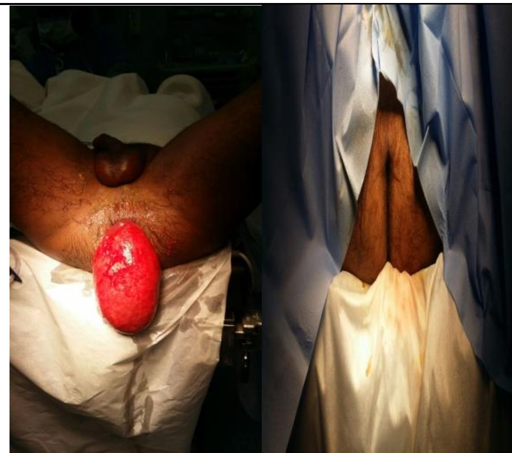
Introduction

Rectal prolapse is classified into complete or full thickness prolapse and incomplete or mucosal prolapse. Complete prolapse occurs in older adults while the latter occurs both in children and adults. This report is based on complete rectal prolapse, which is rare in males and it is associated with weak pelvic and anal musculature. Rectal prolapse is an anatomical abnormality and mostly ll' requires surgical correction.

Case Report

A 26-year-old Indian male not known to have any medical problem except for hypertension, was presented to Emergency Room of King Khalid Hospital Hail with a huge painful protruding mass through the anus since few 4 prior to presentation . The patient had no similar presentation and denied any history of chronic constipation or incontinence. General physical examination was normal. Systemic and abdominal examination was normal. Per- rectal examination revealed large protruding rectal mass with oedema and a thickened congested wall (Figure:1a).A diagnosis of giant irreducible complete rectal prolapse has been made. A gentle trail of concervative treatment and manual reduction unfortunately failed .

Address for Correspondence: Dr. Alaa Mohamed Sedik, Department of General Surgery, King Khalid Hospital, Hail, Saudi Arabia. E-mail: asedik59@yahoo.com



(a) (b)

Figure :1 (a) Intraoperative photo taken perfore the successful manual reduction under GA showing the giant viable complete rectal prolapse .(b) successful result with complete reduction after gentle manual reduction.

The situation discussed fully with our patient about possibility of perineal rectosigmoidectomy should reduction fail with possibility of loop ileostomy .The patient was taken to the theatre and successful reduction was done under general anesthesia(Figure:1b).Postoperatively ,he was kept in the hospital and Colonoscopy was done and showed no abnormality. The situation was discussed with the patient about the available options. Informed consent was obtained. The patient was prepared in the nearest elective list for open mesh

rectopexy using a prolene mesh fixed to the sides of rectum with interrupted prolene 2/0 stiches and to the presacral fascia with tacker fixation device. Before closure ,a rigid sigmoidoscopy was used to confirm proper placement of sutures avoiding the rectal mucosa. Also the anterior wall of rectum was not covered by the mesh. At the end of surgery, saline wash was done and a drain was left in the pelvis then the peritoneum closed over the mesh .The abdomen closed with mass closure technique and skin clips applied. Postoperatively, he made uneventful recovery and discharged in a good condition .He was followed in outpatient clinic for several months and showed no recurrence .

Discussion

There is still some debate about the exact pathophysiologic mechanism of RP. The prevailing theories are those of sliding herniation and progressive internal intussusception. The most usual form of RP is the chronic course of the disorder, incarcerated or strangulated RP is a rare scenario, where urgent surgical treatment becomes a priority [1].
Anal manometry, anal ultrasound, defecography, anal electromyography, pudendal nerve terminal motor latency test, sigmoidoscopy, colonoscopy and magnetic resonance imaging are tests used in evaluation of rectal prolapse.

Initially there is a conservative management for rectal prolapse with stool softeners or laxatives and avoidance of prolonged straining. These conservative methods allow reduction of the prolapsed rectum. Oedema may be reduced by the application of sugar, by the injection of Hyaluronidase, or by applying an elastic compression wrap[2-4]

A wide spectrum of operative procedures are available mainly for elective cases [5]. They are categorized as resective, fixative or a combination of both in order to achieve 2 goals: anatomical repositioning of the bowel and improvement of the function of the anorectal complex. The approach may be either abdominal or perineal.
Abdominal approaches are performed in patients fit enough to tolerate laparotomy as these seem to result in lower recurrence rates [6], perhaps with the exception of young men who cannot afford the increased risk of impotence and infertility from an abdominal operation[7]. In elective cases, rectopexy, using fixing material (mesh, sutures, clips), is the most popular operation with good results concerning recurrence [8,9]. In the modern era of surgery, the above operations can be accomplished laparoscopically with minimal morbidity and mortality [10].

When the prolapsed bowel is incarcerated or strangulated and cannot return to its anatomic position, an urgent surgical intervention is always indicated. The operation of choice is perineal proctosigmoidectomy with or without colostomy [11-13].

Conclusion

The surgical procedures for rectal prolapse are diverse, indicating that the precise etiology and treatment strategy have not been clearly established. If the best procedure is to be selected and favorable outcomes achieved, careful considerations of patient's information and surgeon's clinical experience are required. Unlike surgery for malignancy, the functional aspects, such as quality of life and defecation, should be considered carefully in surgery for rectal prolapse. Attention should be paid to multidimensional patient care, as well as surgical techniques. Particularly, rectal prolapse patients may have a uterine prolapse or a bladder prolapse; thus, a multidisciplinary team approach may also become important. For the best results, a considered plan prior to surgery, optimal surgery by an experienced hand and careful patient care are important.

Author Contribution

All authors contributed to conception and design, manuscript preparation, read and approved the final manuscript.

Conflicts of Interest

The Authors declares no conflict of interest.

Funding

Nil

References

[1] Ramanujam PS, Venkatesh KS. Management of acute incarcerated rectal prolapse. Dis Colon Rectum. 1992; 35: 1154-1156.

[2] Seenivasagam T, Gerald H, Ghassan N, Vivek T, Bedi AS, Suneet S. Irreducible rectal prolapse: emergency surgical management of eight cases and a review of the literature. Med J Malaysia 2011 Jun;66(2):105-7.

[3] Coburn WM 3rd, Russell MA, Hofstetter WL. Sucrose as an aid to manual reduction of incarcerated rectal prolapse. Ann Emerg Med 1997 Sep;30(3):347-9.

[4] Chaudhuri A . Hyaluronidase in the reduction of incarcerated rectal prolapse: a novel use. Int J Colorectal Dis 1999 Nov;14(4–5):264.
[2] Kuijpers HC. Treatment of complete rectal prolapse: to narrow, to wrap, to suspend, to fix, to encircle, to plicate or to resect? World J Surg. 1992; 16: 826-830.
[3] Madiba TE, Baig MK, Wexner SD. Surgical management of rectal prolapse. Arch Surg. 2005; 140: 63-73.
[4] Bastawrous A, Abcarian H. Complete rectal prolapse. In: Dempsey DT, Klein AS, Pemberton JH, Peters JH, editors. Suckelford's Surgery of the alimentary tract. Volume 2. 6th edition. Philadelphia: Saunders Elsevier; 2007. pp. 1958-1965.
[5] Tjandra JJ, Fazio VW, Church JM, Milsom JW, Oakley JR, Lavery IC. Ripstein procedure is an effective treatment for rectal prolapse without constipation. Dis Colon Rectum. 1993; 36: 501-507.
[6] McCue JL, Thomson JP. Clinical and functional results of abdominal rectopexy for complete rectal prolapse. Br J Surg. 1991; 78: 921-923.
[7] Solomon MJ, Young CJ, Eyers AA, Roberts RA. Randomized clinical trial of laparoscopic versus open abdominal rectopexy for rectal prolapse. Br J Surg. 2002; 89: 35-39.
[8] Habr-Gama A, Jacob CE, Perez RO, Proscurshim I. Rectal prolapse: Perineal approach. In: Fischer JE, Bland KI, editors. Mastery of Surgery. Volume 2. 5th edition. Philadelphia: Lippincott Williams and Wilkins; 2007. pp. 1591-1599.
[9] Miles WE. Rectosigmoidectomy as a method of treatment for procidentia recti. Proc R Soc Med. 1933; 26: 1445-1452
[10] Altemeier WA, Culbertson WR, Schwengerdt C, et al. Nineteen years' expeience with the one-stage perineal repair of rectal prolapse. Ann Surg. 1971;173:993-1006
[11] Ramanujam PS, Venkatesh KS, Fietz MJ. Perineal excision of rectal procidentia in elderly high-risk patients. A ten-year experience. Dis Colon Rectum. 1994; 37: 1027-1030.
[12] Brown AJ, Anderson JH, McKee RF, Finlay IG. Strategy for selection of type of operation for rectal prolapse based on clinical criteria. Dis Colon Rectum 2004 Jan;47(1):103-7.
[13] Fang SH, Cromwell JW, Wilkins KB, Eisenstat TE, Notaro JR, Alva S. Is the abdominal repair of rectal prolapse safer than perineal repair in the highest risk patients? An NSQIP analysis. Dis Colon Rectum 2012 Nov ;55(11):1167-72.