PRIMARY ENTEROCELE WITH RECTOCELE AND RECTAL PROLAPSE

(Report of a Case)

by

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Primary enterocele is an uncommon condition. Gemmel (1949) reported an incidence of 1 in 400 cases of genital prolapse. A secondary enterocele is more commonly seen either after ventral fixation, vaginal or abdominal hysterectomy. Swami and Vyas (1967) reported a case of primary enterocele occurring alone.

The case presented here was a remarkable primary enterocele combined with rectocele as well as prolapse of the anterior rectal wall. A developmental abnormality could be the basis of its origin.

Case Report

Mrs. M., aged 62, was admitted to the Government Maternity Hospital, Hyderabad, on 31st October, 1960 for having to strain excessively during defaecation during the past eight years. She also noticed a mass coming down per vaginam on straining since a year. She had been suffering from cough for two years.

The onset of menarche was at 13 years and the menstrual periods had been normal. She was married at the age of 19 and had seven full-term normal deliveries at intervals of two years. The last delivery was 28 years ago. No undue difficulty was experienced during her deliveries which took place at home. She used to get back to domestic duties at about the twentieth day each time. Menopause commenced 14 years ago.

The patient was a sparsely built woman. Her blood pressure was 120/90 mm of Hg. The cardio-vascular and respiratory systems were normal. Abdominal palpation did not reveal any abnormality.

On pelvic examination a large pink bulge (Fig. 1) was noted in relation to the posterior vaginal wall. There was no tendency to any prolapse in relation to the anterior vaginal wall even on straining. There was no descent of the uterus. Bimanual examination showed an anteverted, atrophic uterus. No abnormality was noted in the fornices. The levatores ani were of poor tone. There was also a prolapse of the mucosa of the anterior rectal wall. A rectal examination confirmed the presence of both a rectocele and above that an enterocele. The tone of the anal sphincter was good.

The case was diagnosed as one of primary enterocele associated with rectocele, as well as prolapse of the anterior rectal wall. Hence it was decided to carry out a repair of the hernia combined with a colpo-perineorraphy. Excision of the prolapsed rectal wall would also be necessary.

Results of routine laboratory investigations were within normal limits.

On 19th November, 1960, a plastic procedure was carried out under spinal anaesthesia. (Fig. 2 shows a finger in the rectum defining the bulge clearly as a rectocele. The enterocele is being retracted by the handle of the uterine sound). The edge of skin between the posterior vaginal wall and the perineum was excised with a pair of scissors. The vaginal wall was reflected right up to the junction of the vaginal vault

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with the cervix exposing both the rectocele and enterocele. The enterocele was now isolated (Fig. 3) and excised after placing at its neck a purse string suture using No. 0 chromic catgut. This suture was then fixed to the back of the uterus at the level of the isthmus. The anterior rectal fascia which was attenuated was plicated with interrupted No. 0 catgut sutures. The inner borders of the levatores ani were then picked up with Allis forceps and brought together by means of interrupted sutures applied with similar catgut. Redundant vaginal wall was excised and the edges were stitched together with interrupted sutures. The prolapsed rectal wall was excised transversely and haemostasis secured. A catheter was left in situ and the vagina packed with gauze. This was removed after 24 hours.

Discussion

Kirk *et al* (1947) and Uhlenhuth *et al* (1948) have adduced by dissecting adult and foetal pelvic structures, ample anatomical evidence to show the origin of the pouch of Douglas. They showed that the 'recto-vaginal septum' is formed by the fusion of ventral and dorsal layers of the peritoneal processes which extend to the perineal body in early foetal life. At times, it might be possible in adult life for this fusion to get undone by increased intra-abdominal pressure leading to the formation of an enterocele. This would then be of the 'pulsion' variety in contrast to the 'traction' type developing in conjunction with the more common type of utero-vaginal prolapse (Read 1949). Enterocele is defined by Read (1951) as a term embracing all abnormal protrusions of the cul-de-sac. A congenital enterocele need not always be associated with the passage of a viscus through the hernial orifice, as is found in umbilical and inguinal herniae. Malpas (1957) recognises a primary enterocele when the posterior fornix is the leading part and secondary when the cervix or the vault after a hysterectomy forms the leading part of the prolapse. The recognition at the stage of primary enterocele is rare as it may soon be followed by general prolapse. As unusually deep pouch of Douglas may form a hernia through the anus by pushing the weakened anterior rectal wall before it and causing a rectal prolapse. In some patients the sac bulges into the rectum and vagina straddling the perineal body Orgias (1965) Symmonds and Pratt (1960) advocate 'lateral fixation' of the ligaments during vaginal hysterectomy in preventing a prolapse of the vault at a future date.

Once an enterocele is diagnosed, whether primary or secondary in type, excision of the sac and closure of its orifice followed by a posterior repair would lead to adequate relief. On occasion, an attempt at obliteration of an unduly deep pouch of Douglas through the abdominal route by Moschowitz (1912) sutures may be indicated. It needs to be emphasized that a rectal prolapse should not be treated by mere resection of the protruding rectal wall but by restoring the relation of the pelvic fascia to the rectal wall and reformation of the recto-vaginal septum as suggested by Graham (1942).

Conclusions and Summary

Although genital prolapse of the massive and irreducible types is common among gynaecological conditions here, primary enterocele was not

encountered before this case came in. The cause of this condition could possibly be re-opening of a potential peritoneal sac in the recto-vaginal septum, perhaps by increased intra-abdominal tension. Satisfactory repair was effected by paying attention to the hernia and a good perineorrhaphy.

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Figs. on Art Paper XIV