PROLAPSE RECTUM ASSOCIATED WITH PROLAPSE UTERUS

(Report of Two Cases)

by

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Introduction

Prolapse uterus is no new entity for a gynaecologist nor prolapse rectum for a surgeon. But combined rectal and uterine prolapse is a rare condition one comes across. Literature also presents few such cases. Banerji (1963) from Calcutta has reported 3 cases of rectal prolapse in women out of which only 1 was combined with genital prolapse. The second was associated with inversion of uterus. His case was treated by Moschowitz operation. Sirkar (1971) has reported one such case treated by conservative surgery. During our experience of 16-17 years, we came across 2 cases at Government Medical College and Civil Hospital, Surat.

CASE REPORTS

Case 1

Patient, Mrs. P., aged 45 years, admitted on 1st October, 1974 with C/O something coming out per rectum since 22 years, something coming out per vaginam for 8-10 years and difficulty in micturition 3 to 4 years. She had 6 full term normal deliveries, all children are living and 4 abortions and thus she was a grandmultipara. Her menstrual history was normal. On general examination nothing abnormal was detected. Cardiovascular and respiratory systems were normal. On perineal examination extensive rectal prolapse was seen and there was third degree prolapse of the uterus. (Fig. 1). On vaginal examination uterus was normal in size and fornices were free.

Investigations

Hb—10.0 gm.%. Other blood indices within normal limits. Other investigations within normal limits.

As she was suffering from amoebic dysentry, she was treated for amoebiasis. Surgeon was consulted and joint attempt was made for surgical repair. On 4th November, 1974. The abdomen was opened by left paramedian incision from umbilicus to symphysis pubis. On opening abdomen, it was seen that the supports of the uterus and cervix were very lax. There was deep pouch of Douglas (Fig. 2). Total abdominal hystrectomy and rightsided salpingo-ophorectomy was done in routine fashion. The cystocele was repaired by abdominal route. The prolapse rectum was repaired abdominally. The rectouterine pouch was found to be very deep. The musculature of rectal floor was very lax. An incision was made on the side of the loose part of sigmoid colon and rectum and the ureters were identified and safeguarded. A circular incision was then made around the rectum through the peritoneum. Rectum was dissected anteriorly upto the vault of the vagina and posteriorly. It was mobilised as low as the pelvic diaphragm. The pubo-rectalis muscle was separated. Rectum was pushed anteriorly and the pubo-rectalis muscles of both sides were approximated behind

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Accepted for publication on 12-9-1977.

the rectum by 4 silk sutures (Fig. 3). The mobilised rectum and distal part of the sigmoid colon were then extraperitonised and dissected as in Lahauts operation. This was done by dissecting internal and lateral leaves of the parietal peritoneum from the abdominal wall. The inferior epigastic vessels were ligated. The peritoneum was sutured behind the rectum and lower part of sigmoid colon. The extraperitonised bowel was also sutured with the peritoneum at the side of entrance and exit at the anterior rectus sheath (Fig. 4) and the skin were then closed in front of the bowel. The patient was given 300 cc. of blood and 2 pints of dextraven during the operation.

The postoperative period was uneventful. The patient passed flatus and stool on 6th postoperative day. She had intermittent attacks of constipation. At the time of deafecation reflex she had a feeling of discomfort in the abdomen where intestine was brought forward. She had some loss of confidence. Both the difficulties she overcame gradually. She was discharged on 18th postoperative day when she had good sphincter control. There was no descent either of the rectum or the vault of vagina even on straining. She reported six weeks later and was completely well.

Case 2

Mrs. L.N., aged 35 years, admitted on 4th February, 1975 for something coming out of vagina 10 months and something coming out of rectum since 10 months. She had difficulty in micturition and constipation off and on since 8 months. She had undergone 2 full term deliveries. Her menstrual history was normal. On general examination nothing abnormal was detected. Cardiovascular and respiratory system were normal. On perineal examination rectal prolapse was seen and there was second degree uterine prolapse. On vaginal examination uterus was of normal size and fornices were free.

Investigations

Hb—9 gm.%. Other investigations were within normal limits.

This patient was also suffering from amoebic dysentry for which she was treated. Surgeon was consulted and joint attempt was made for surgical repair. The abdomen was opened by left paramedian incision and the intestines were packed off. The peritoneum at the rectouterine pouch was incised. This incision was then extended on both sides of the rectum. Rectum was mobilised by blunt dissection anteriorly upto the posterior wall of vagina. Similarly it was mobilised from the sides and posterior aspect upto floor of the uterus. Ureters were safeguarded during this procedure. Sacral promontory was cleared. The mobilised rectum was elevated. It was stiched posteriorly over the longitudinal ligament of the sacral promontory by 3 stout silk sutures on either side of the midline. The sutures passed through the rectal facia and muscle ccat of the rectum.

Next, the posterior surface of the vagina was cleared and 3 silk sutures were passed on either side of the midline taking bits of muscle and fascia of rectum and fascial layer of vagina. The sutures were tied. The anterior wall of the rectum thus got fixed with the posterior wall of vagina. The redundant peritoneum of rectouterine pouch was excised and the pouch was completely obliterated, complete haemostasis was secured. The cystocele was repaired abdominally. The vesicouterine fold of peritoneum was incised transversely. The bladder was dissected away from the vagina and bladder pillars were made prominent. The bladder pillers were sutured between the vagina and the bladder with chromic catgut. After that anterior peritoneum was closed and the round ligaments were plicated to antevert the uterus. Abdomen was closed in layers.

Postoperative Notes

Postoperative period was practically uneventful. The patient could pass flatus and stool on third postoperative day. Stitches were removed on 7th day. There was no prolapse of rectum or the uterus even on straining. She was discharged on 8th day. She came for postoperative check up one month later and had no trouble at all.

Discussion

Prolapse uterus combined with prolapse rectum is a rare clinical entity. A few cases have been reported in literature. The etiology of prolapse uterus needs no comment. The simultaneous rectal prolapse is accounted by the presence of congenitally deep pouch of Douglas. Associated with this, there may be weakness of rectovaginal septum and the levator

ani. This brings about a sliding hernia of anterior rectal wall along with its eversion through anal sphincter. With a huge rectal prolapse posterior rectal wall is simultaneously turned inside out. Our first case had a huge rectal prolapse and in second case the prolapse was more confined to the anterior rectal wall. Because of huge rectal prolapse the first case required treatment by extensive surgery. The second case could be dealt with simple repair procedure.

Summary and Conclusion

Two unusual cases of prolapse uterus with prolapse rectum are presented for clinical interest because of rarity of condition. The etiology of rectal prolapse is discussed in short.

Acknowledgement

We thank Dean, Government Medical College, Surat for allowing us to use hospital records.

References

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2. Sirkar, R. L.: J. Obst. & Gynec. of India 21: 222, 1971.

See Figs. on Art Paper VII