COMPLETE RECTAL PROLAPSE WITH PROCIDENTIA

(Report of One Case)

by

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Minor anal and rectal conditions such as complete perineal tear, recto-vaginal fistula etc., which are commonly seen in gynaecologic patients are treated by gynaecologists. But complete rectal prolapse along with complete uterine prolapse is rarely encountered in gynaecologic patients and is usually managed by gynaecologists with the help of a general surgeon Banerjee (1963), Sarkar (1971), and Parikh (1977), reported some such rare cases and managed their cases jointly with surgeons. In this paper the author is presenting another such rare case a new operative technique, where gynaecologist alone can give relief to the patient is described.

Case Notes:—

S.B. 59 years Para 8 + 0 was admitted on 12-8-73 at S.N. Pandit Hospital, Calcutta with complaints of something coming down per rectum for last 5 years and per vaginum for last 8 years. She was having difficulty in micturition and defaecation for last 2 years. Past confinements were normal. Menopause for 15 years. For the last 5 years she was suffering from chronic cough and occasional diarrhoea and lost considerable weight. On examination, she was anaemic with evidence of bronchitis and weak abdominal muscles. Gynaecological examination revealed combined complete uterine and rectal prolapse, with very weak pelvic floor. Routine stool examination showed ankylostomiasis, undigested food materials and fat. All other reports, even I.V.P. were within normal limit.

Management

After preliminary treatment of bowel condition operative correction of both the prolapsed organs was done at one time.

Operative Technique

Following removal of the uterus in the usual method, posterior vaginal wall was dissected free from anal and rectal wall from introitus upto posterior vaginal vault as in high perineorraphy. Rectum was mobiilsed from below upwards. Rectum was then pushed upwards and backwards and the pubo-rectalis muscles were drawn together in front of the rectum with four non-absorbable sutures. Posterior peritoneal pouch was dissected free as high as possible and then excised and sutured with absorbable sutures to the rectum and utero-vaginal pouch of peritoneum, thus closing the peritoneum. Vaginal vault and cystocele were repaired in usual method. Para-rectal fascia was approximated by interrupted sutures. Redundent posterior vaginal wall was removed and sutured upto mid-vagina. Levator ani along with perineal groups of muscles were sutured in the midline. A rectal tube (½ inch diameter) was passed upto 5 inches above the anal opening and external anal sphincters were sutured by a subcuticular pursestring suture around the rectal tube. Rest of the vaginal wall and skin were sutured as usual.

Post Operative

Post operative period was uneventful and rectal tube was removed on 4th post operative period.

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Follow Up

Patient attended follow up clinic till February 1980 and there was no recurrence.

Discussion

Operation described in this paper was based on the principles of Goligher's modification of Grahams operation. The essential steps were mobilisation of rectum, suture of the para-rectal tissue and puborectalis muscles in front of the rectum, approximation of external anal sphincter and excision of the abnormally deep peritonal sac. Most of the surgeons adopted abdomino-vaginal route to achieve the above principles, but the present author did it through vaginal route alone. For last 8 years the patient is perfectly normal, suggests further trial to prove whether the new operation will stand the test of time.

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