RECTAL PROLAPSE

(Report of 3 cases with review of literature)

by

NIKHIL S. MUNSHI,* M.D., D.G.O., D.F.P.
(MRS.) PRATIBHA R. VAIDYA,** M.D., D.G.O., F.C.P.S., D.F.P.
and
GEETA S. RAO,*** M.D., D.G.O.

Rectal prolapse in women is often associated with genital prolapse. However, prolapse of the rectum through the anus is not a very common finding during gynaecological examination. We are reporting 3 cases of rectal prolapse with uterovaginal prolapse along with the review of literature on the same.

CASE REPORT

Case 1:

Mrs. G.K. 75 years old Hindu female was admitted for vaginal spotting off and on for last 2-3 months and something coming out per anum for last 5 years. She complained of diarrhoea off and on for last 1 year.

She was menopausal for 20 years and past menstrual cycles were normal.

She had 7 F.T.N.D., last child was 25 years old. Systemic examination was normal. Muscular tone of the abdominal wall was good. Examination showed atrophic senile vaginitis with minimal utero-vaginal prolapse. On vaginal examination atrophic uterus was felt with clear pelvis. There was a complete rectal prolapse without bleeding or ulceration. Sphincter tone was fair. After building her up abdominal panhysterectomy with Graham's repair was done. Patient was recovering well but on the 7th day developed pulmonary embolism and died.

Case 2: Hindu female, Mrs. U.K., 25 years old came with history of something coming out per vaginum for 6 months and per anum for last 2 years and secondary sterility. Symptoms were aggravated for last 6 months. Her menstrual history was normal. She had 1 F.T.N.D. 6 years ago.

She was fairly built and nourished. Systemic examination was normal. Local examination revealed second degree descent, with slight cystoecele and no rectocele. There was total rectal prolapse with normal mucosa. Tubal patency test, plication of round ligaments was done along with the Graham's operation for rectal prolapse and cervicopexy through a pfanennestiel incision. Patient made an uneventful recovery postoperatively and is still well on follow up examination. Photograph No. 1.

Case 3: Mrs. A.M., 50 years old Hindu female was admitted on 15-5-1980 with history of something coming out per vaginum for last 4 years and rectal prolapse for last 4-5 years. She had difficulty in defaecation and constipation.

She was menopausal for last 5 years, her previous cycles were normal. She had 4 F.T.N.D., last one 15 years ago.

Her general and systemic examination did not reveal anything significant except severe anaemia. On examination she had utero-vaginal prolapse with cystocele, rectocele and enterocele. There was hyperkeratinization of vaginal walls and a decubitus ulcer on the cervix.

*Reader.
**Professor and Head.
***Tutor.
Accepted for publicatinn on 23-5-81.
From Dept. of Obstetrics and Gynaecology, L.T.M.M.C. and L.T.M.G.H. Sion, Bombay 400 022.

Her ulcer was treated with vaginal tampoon insertion.

Abdominal panhysterectomy and Graham's repair was done. The patient developed burst abdomen on 7th post operative day. Post operative course was uneventful after resuturing.

Discussion

In our cases hysterectomy was done in 2 cases. Tubal testing, plication of round ligaments Graham's repair of rectal prolapse and cervicopexy were performed in one case through a Pfennenstiel incision. This combination is not reported in the literature to our knowledge. There is no recurrence or incontinence for last one year in this case.

Our first patient expired on 7th day of post operatively due to sudden pulmonary embolism. The third patient had burst abdomen. These could be avoided by vaginal approach with restoration of pelvic floor and vaginal rectopexy, especially in elderly women with poor surgical risk. However we wonder whether this could have been successful in pulling the posterior rectal wall in these cases of complete rectal prolapse.

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See Fig. on Art Paper IV