Rectal prolapse in 89 years old woman ; a case report

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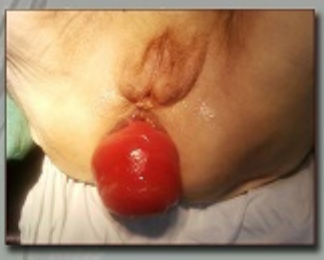
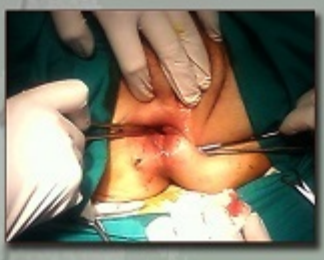
Introduction

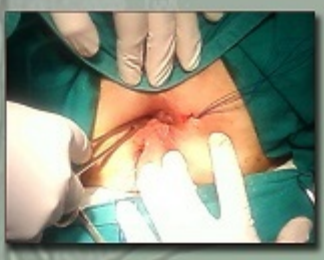
Rectal prolapse is rear entity , of the three conditions : mucosal prolapse, internal intussusception and full thickness prolapse our case refers to the later been a protrusion of the full thickness of the rectal wall trough the anus. Incidence of the condition is unknown but the peak of occurrence is after seventh decade and most of the patients (80%) are women.
The etiology is also unknown ,but it is associated with predisposing conditions like long-standing constipation, prolonged straining with defecation, multiple pregnancies , previous surgery , neurologic disease . Also there are some anatomic features that are related with rectal prolapse like weak or patulous anal sphincter with levator diastasis , deep anterior Douglas cul-de-sac, redundant rectosigmoid wit poor posterior fixation . Whether these features are cause or result of prolapsing rectum is not clear. Surgical treatment can be divided in two categories –perineal and abdominal. Abdominal procedures have low recurrence rate but higher morbidity and mortality.

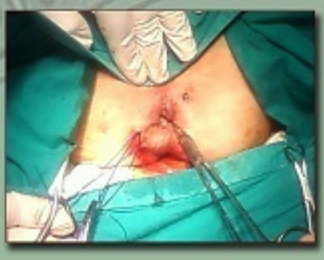
Case presentation

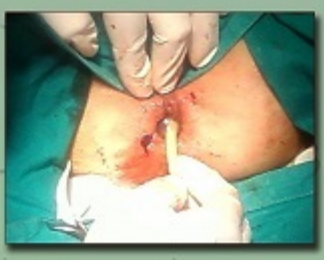
We present a case of a 89 years old woman with protruding mass trough anus with mucosal erosions and signs of recent bleeding. She has mucus discharge, and incontinence , but also constipation and outlet obstruction. Cardiopulmonary disease(COPD) and anemia were part of medical history. The patient had 5 pregnancies and long standing constipation before presenting with rectal prolapse. When we replaced the prolapsing rectum weakness of the anal sphincter was evident and it prolapsed and remained continuously prolapsed immediately after we released the pressure . Basic laboratory tests and colonoscopy were concluded preoperatively . The bowel was prepared mechanically and preoperative intravenous antibiotics were used. Perineal procedure - anal encirclement (Thiersch wire) was preformed. Two small incisions anterior and posterior – 1cm outside the anal verge were made and non absorbable monofilament size 2 suture was passed on either side of the anus in the ischiorectal fossa. Luminal size of the anal orifice was determined with Foely catheter 18Fr filled with 6 ml of water (20mm diameter).Two wounds were closed primarily with absorbable sutures.
Stool softeners and laxatives were used postoperatively the discharge was 5 th post operative day after bowel function was established

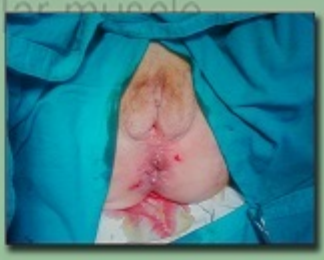












Conclusion

To the best of our knowledge there are more than 100 procedures described for the treatment of this condition. The method we used is only effective in mechanically preventing the rectum from prolapsing and it is not treating the underlying disorder.It is not the method to be recommended but considering our patient overall medical condition we think it was a method of choice.