Approach to concomitant rectal and uterine prolapse: case report

Uterin prolapsusa eşlik eden rektal prolapsusa yaklaşım: Olgu sunumu

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Abstract

The classic description of rectal prolapse is a protrusion of the rectum beyond the anus. Peaks of occurrences are noted in the fourth and seventh decades of life, and most patients (80-90%) are women. The condition is often concurrent with pelvic floor descent and prolapse of other pelvic floor organs, such as the uterus or the bladder. In this study, two cases having contraindication to general anesthesia with rectal and uterine prolapse are presented. These cases were operated on under local anesthesia with support of sedation by Leforte and Delorme's operation at the same time. In conclusion; pelvic floor disorders should be considered as a whole, and surgical correction of rectal prolapse and uterine prolapse may be done at the same time under local anesthesia with the support of sedation. Performance of these operations by experienced and trained pelvic reconstructive surgeons may be advocated.

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Özet

Rektal prolapsusun klasik tanımı rektumun anüsün dışına sarkmasıdır. Yaşamın dördüncü ve yedinci dekatında pik yaptığı gösterilmiştir ve hastaların %80-90'ı kadındır. Bu durum genellikle pelvik tabanda iniş ve diğer pelvik taban organlarının prolapsusu (mesane ve uterus gibi) ile birliktedir. Bu çalışmada genel anestezi için kontrendikasyonu olan ve rektal ve uterin prolapsuslu iki olgu sunulmuştur. Bu olgular lokal anestezi ve sedasyon altında, aynı seansta, Delorme ve Lefort operasyonlarıyla opere edildi. Sonuç olarak; pelvik taban hastalıkları bir bütün olarak düşünülmelidir ve rektal ve uterin prolapsusun cerrahi düzeltilmesi lokal anestezi altında aynı seansta yapılabilir. Bu operasyonları deneyimli ve eğitimli pelvik rekonstrüktif cerrahların yapması daha doğru olabilir. (J Turkish-German Gynecol Assoc 2012; 13: 70-3)

Anahtar kelimeler: Rektal prolapsus, Delorme operasyonu, lokal anestezi
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Introduction

The rectal prolapse or procidentia is defined as a protrusion of a part or all of the rectum beyond the anus (1). The rectal prolapse is associated with pelvic floor disorders in approximately 18-27%, and floor disorders are also associated in 36-80% with stress urinary incontinence, 36% anorectal disease, 19% fecal incontinence and constipation (2-6). Therefore, genital organ prolapse and rectal prolapse may coexist, and each of them is a part of pelvic floor disorders (4, 5). The patients with pelvic organ prolapse apply to a gynecologist more frequently. Under the circumstances, not only genital organ prolapse but also all of the pelvic floor should be examined and concomitant rectal prolapse and/or fecal incontinence should not be overlooked.

In the present study, the surgical approach applied to two cases with concomitant rectal prolapse and pelvic organ prolapse operated on in our clinic is discussed.

Case Reports

Case 1

A 77-year-old woman patient was admitted to our department with complaints of anal distension and a mass prolapsed from the vagina. The patient had had these complaints for three years but her complaints had increased recently. She had had five babies delivered vaginally and forceps was only used in the second birth in her obstetric history. Stage IIIa prolapse according to POP-Q (pelvic organ prolapse quantitative) and stage I rectal-mucosal prolapse according to Altemeier's staging were determined in her pelvic examination. In addition, she had had hypertension for twenty years and chronic obstructive lung disease for fifteen years.

Case 2

A 83-year-old woman patient was admitted to our department with complaints of anal distension, with a mass prolapsed

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from the vagina. The patient stated that she had had these complaints for five years and recently she was having trouble and stress while doing housework. In her obstetric history, largest one was 4100 gr, she had had six vaginal deliveries at home performed by a midwife. In her pelvic examination, stage IIIb prolapse according to POP-Q, stage I rectal-mucosal prolapse according to Altemeier's staging and loss of anal circular muscle tone were determined. In addition, she had had a history of heart failure for five years and was receiving medical treatment because of heart failure.

Operative technique

Preoperatively, local estrogen preparations were given twice a day for ten days. Mechanical bowel preparation was started 48 h before surgery and ceftriaxone 1 g and metronidazole 500 mg were administered intravenously 30 min before surgery.

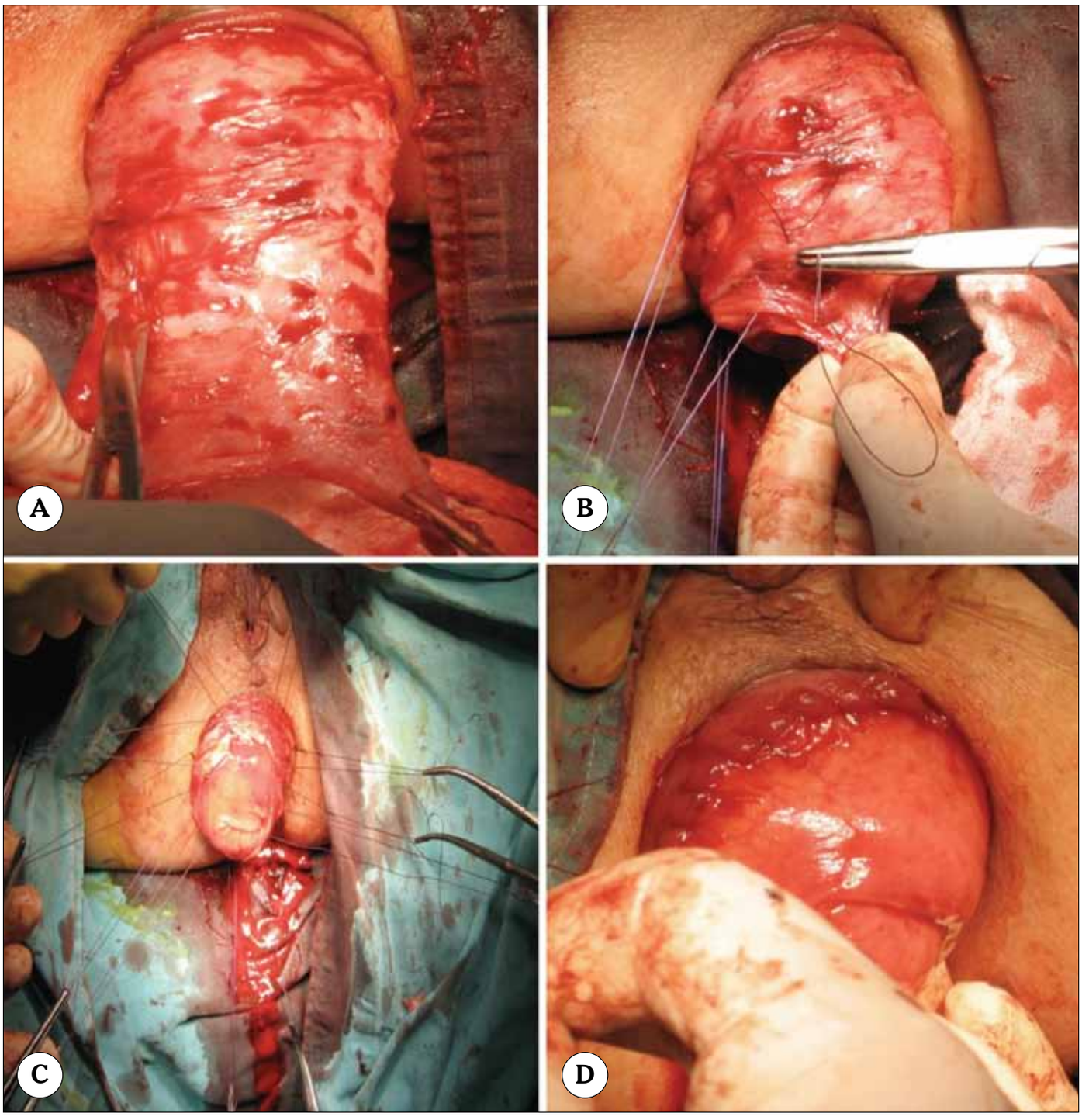

Figure 1. (Delorme's operation). Rectal mucosa was stripped by sharp dissection (A), vertical plications were made to rectal mucosa (B-C) and rectal mucosa was sutured, end to end (D)

The operation was carried out under local anesthesia with the support of sedation due to systemic decompensation. Lefort's operation (colpocleisis) for uterine prolapse and Delorme's operation for rectal prolapse were carried out at the same time. For rectal prolapse, the prolapse was fully extended using Babcock forceps and sufficient 1:400 000 adrenaline solution was injected submucosally to elevate all the exposed mucosa. This facilitated dissection in that plane and greatly reduced bleeding. Later, a circumferential mucosal incision was made 10-15 mm from the mucocutaneous junction and the mucosa was dissected proximally, the mucosa was stripped from the rectum to the apex of the prolapse and excised (Figure 1A).

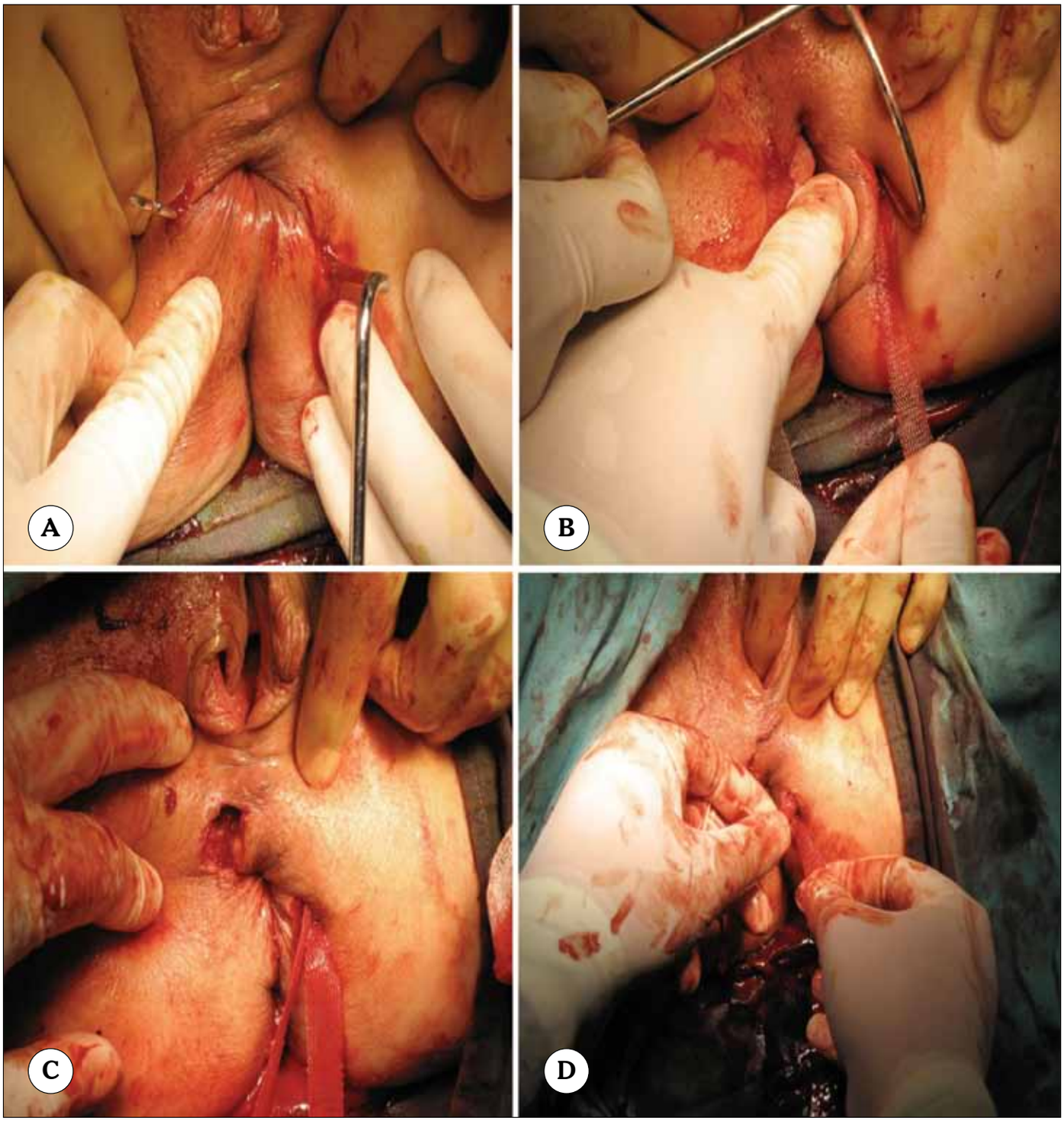

Figure 2. (Thiersh's operation) The curved needle was entered at 3 o'clock point by moving forward behind the sphincter and removed at 9 o'clock point (A), and was withdrawn by placing mesh at the apex (B), this process was repeated by passing in front of the sphincter and the mesh was placed around the anal sphincter circularly (C). Finally, the apexes of the mesh were connected to each other (D)

Between 8 and 12 plicating sutures of an absorbable material were inserted in the muscular wall of the rectum between the mucosal cut edges at the mucocutaneous junction and the apex (Figure 1B, 1C). Then, the denuded prolapsed muscle was pleated with a suture and was reefed up like an accordion (Figure 1B, 1C). The transected edges of the mucosa were then sutured together (Figure 1D). Later, Thiersh's procedure was used and the purpose of this procedure was to keep the rectum from prolapsing by restricting the size of the anal lumen. A polypropylene mesh was placed for anal canal encirclement. A curved needle was inserted at the 3 o'clock position around the anal canal, progressed subcutaneously, removed at 9 o'clock (Figure 2A) the and curved needle was withdrawn by placing mesh at the apex (Figure 2B). This process was repeated in the front and back of the anal canal, and as a result, mesh material was positioned to surround the external anal sphincter (Figure 2C). Finally, the polypropylene mesh was connected end to end (Figure 2D) and operation was completed. Postoperatively, antibiotic therapy was continued for 7 days, low molecular weight heparin was started in the twelveth hour. Oral feeding was stopped for the first two days. After this period, liquid nourishment was started and rapidly advanced to a regular diet. Difenoxylate + atropine sulfate was implemented four times a day to prevent rectal contamination.

Discussion

Rectal prolapse is an anatomical disease that is a component of pelvic floor dysfunction and it affects the quality of life adversely. This disease is seen in the elderly population more frequently or in patients who have a contraindication to general anesthetia. Our cases were at high risk for operations under general anesthesia, Lefort and Delorme operations were carried out at the same time under local anesthesia with the support of sedation. In this manner, possible mortality and morbidity due to general anesthesia were minimized and rectal prolapse was repaired at the same time. In the surgical treatment of rectal prolapse, abdominal procedures and perineal procedures can be preferred. The Delorme operation can be performed in elderly candidates or in patients for whom general anesthesia would constitute a high risk because of cardiac or pulmonary co-morbidities (8, 9). The Delorme procedure is expected to be sufficient for correction of anatomic structure, if the degree of rectal prolapse is stage I according to Altemeier's staging (10). Thiersh's procedure can be made around the anal sphincter for the treatment or prophylaxis of anal incontinence (9).

In conclusion, in elderly patients who have additional medical conditions and have concomitant rectal and uterine prolapse, the Delorme and Leforte operations may be applied under local anesthesia with the support of sedation. In addition, subcutaneous placement of mesh around the external anal sphincter may contribute to anal continence. The pelvic floor disorders should be considered as a whole, and evaluation of the pelvic floor should be made by urogynecologists who are experienced and trained.

Conflict of interest

No conflict of interest was declared by the authors.

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