

Complete Rectal Prolapse Together with Total Uterine Prolapse Treated Successfully by Altemeier Operation: A Case Report

Ebru DİKENSOY¹, Fatma Bahar CEBESOY¹, Necdet AYBASTI², Özcan BALAT¹

Gaziantep, Turkey

Rectal prolapse is a rare gynecological condition and rarely occurs together with uterine prolapse. Birth trauma can be rule out as a cause of rectal prolapse like as uterine prolapse. Perineal proctosigmoidectomy is an effective operation for surgical treatment of rectal prolapse. A fifty five years old women was admitted to our clinic for having masses on her genital area. She had chronic constipation for two years. On the pelvic examination; total prolapse uteri, complete rectal prolapse, and third degree cystocele were seen. Vaginal hysterectomy, colporaphy anterior, colporaphy posterior, and perineal proctosigmoidectomy operations were performed. On the postoperative third day, patient was discharged without any complication. Altemeier (perineal proctosigmoidectomy) is a good choice for surgical treatment of the complete rectal prolapse.

Key Words: Rectal prolapse, Uterine prolapse, Perineal proctosigmoidectomy

Gynecol Obstet Reprod Med;15:2 (116-118)

Introduction

Rectal procidentia (complete rectal prolapse) is rare in men older than 45 years of age and in women less than 20 years of age.¹ Most patients requiring an operation are elderly women. Forty to 50% of these women are nulliparous, a number far in excess of that found randomly in women of the same age. Therefore, birth trauma can be rule out as a cause of rectal prolapse like as uterine prolapse. The anatomic features of rectal procidentia include abnormally low descent of the peritoneum covering the anterior rectal wall, loss of posterior fixation of the rectum to the sacral curve, and lengthening and downward displacement of the sigmoid and rectum. Other changes, possibly resulting from the descent of a full-thickness rectal prolapse, include diastasis of the levator ani and an incompetent anal sphincter mechanism.² Altemeier (perineal proctosigmoidectomy) operations approaches the entire problem though the perineum and includes excision of the redundant bowel, obliteration of the hernia sac, and approximation of the levator ani in front of the rectum.³

Case Report

A fifty-five years old woman admitted to our clinic for

complaining about prolapsus uteri and prolapse recti. Her gravidity was 6, parity was 5, abortion was 1. She was in postmenopausal period for 5 years. She had chronic constipation and stress urinary incontinence for 2 years. On her pelvic examination, total prolapse uteri, complete rectal prolapse and third degree cystocele were seen. (Figure 1 shows complete rectal prolapse together with total uterine prolapse before the operations). Her cervix uteri was eroded, and benign cytological changes were seen on the pap-smear test. We did not see any pathological condition on the pelvic ultrasonography. After we gave a local estrogen therapy for ten days, vaginal hysterectomy, colporaphy anterior, colporaphy posterior and Altemeier operation (perineal proctosigmoidectomy), were performed. Preoperatively full mechanical bowel cleansing, oral antibiotics, and single dose intravenous administration were done. The procedures are done in the dorsal lithotomy-Tredelenberg position under spinal anesthesia. First, vaginal hysterectomy, colporaphy anterior and kelly plication, colporaphy posterior operations were done. The levator ani muscles are grasped with Allis clamps. Three to five 0 chromic catgut sutures are used to approximate the edges of the muscle, thus closing the defect in pelvic floor. A general surgeon was performed Altemeier operation. The prolapse is grasped with Allis clamps and is placed on gentle traction to expose the dentate line. An initial circumferential incision is made 3 mm from the dentate line. The sac of the sliding hernia on the anterior surface of the bowel is opened, trimmed, and obliterated with a continuous 3-0 chromic catgut suture making an inverted Y-closure. The thickened mesosigmoid is clamped and cut, and bleeders are secured with 0 chromic catgut. The redundant bowel is then divided into two lateral halves, and holding sutures are placed in each quadrant at the level of the proposed anastomosis, which is then completed

¹Department of Obstetrics and Gynecology and ²Department of General Surgery, Gaziantep University Faculty of Medicine, Gaziantep

Address of Correspondence: Ebru Dikensoy
Gaziantep University Medical Faculty
Department of Obstetrics and
Gynecology, Gaziantep
ebrudikensoy@yahoo.com

Submitted for Publication: 04.12.2008

Accepted for Publication: 20.02.2009

circumferentially with 3-0 chromic catgut. Figure 2 shows the perineal view after the operation.

On the post operative third days we discharged the patient and did not have any complication.



Figure 1: Shows complete rectal prolapse together with total uterine prolapse before the operations



Figure 2: Shows the perineal view after the operations

Discussion

Prolapse of the rectum is the most significant complaint in case of rectal procidentia. After some time, the prolapse occur with the least effort, even with assuming the erect position, and must be reduced manually, but often with no difficulty. There is usually a feeling of bearing down or tenesmus and of incomplete evacuation.⁴ The majority of patients have severe difficulty managing their bowels and complain of constipation, incontinence, or both. Passage of mucus and bleeding may be seen in occult or overt rectal prolapse. Occasionally, uterine prolapse accompanies rectal procidentia.⁵ Physical examination may reveal the prolapsed rectum with thick concentric folds and a posteriorly placed lumen. Palpation of the prolapse reveals that the entire thickness of the rectal wall is

involved. At times, the presence of small bowel in the anterior hernia sac can be diagnosed by observing the peristaltic movements or by eliciting a tympanic note or auscultating peristaltic sounds over the anterior wall of the procidentia.⁶ If the history suggests a rectal prolapse but the procidentia cannot be seen during a routine physical examination, the patient should be asked to squat and strain, and visual or digital examination of the patient's rectum can confirm the diagnosis. Proctosigmoidoscopy reveals congestion and edema of the distal 8 to 10 cm of the rectal mucosa. At times, ulceration and bleeding can be seen easily, but on other occasions a small mucosal ulceration on the anterior wall of the rectum may be the only sign of hidden or occult rectal prolapse. Anal incontinence may due to continuous stretch of the anal sphincter by the prolapsing mass, or it could be due to pudental neuropraxis secondary to down ward displacement of the pelvic floor.⁷ These complications necessitate operation on the prolapse as soon as accurate diagnosis is established. Ulceration and bleeding of the prolapsed mass are common, but excessive hemorrhage is rare. Strangulation and gangrene may result from incarceration. If the prolapse is irreducible and the bowel is nonviable, emergency rectosigmoidectomy is the procedure of choice. Rupture of the prolapse with evisceration is exceedingly rare and requires an emergency operation.⁸

The treatment of rectal procidentia is always surgical. The choice of operative procedures depends not only on the severity of the illness and the patient's risk because of age, cardiovascular disease, and neurologic or psychiatric disorders, but also on the surgeon's experience with a specific technique. For many surgeons, abdominal approaches that is, anterior resection, with or without rectopexy or transabdominal rectopexy as popularized by Ripstein and Wells are easier to master.^{9,10}

The perineal operation popularized by Altemeier and associates and modified by Prasad et al has been shown to have low morbidity and mortality even in poor-risk elderly patients.^{3,11} This method is also ideal for irreducible or gangrenous prolapse. All operations are performed with full mechanical bowel cleansing, oral antibiotics, and single dose preoperative intravenous administration.

Total Uterin Prolapsusla Birlikte Olan Komplet Rektal Prolapsus Altemeier Operasyonu ile Başarılı Bir Şekilde Tedavi Edildi: Olgu Sunumu

Rektal prolapsus nadir görülen jinekolojik bir durumdur ve uterin prolapsusla nadiren birlikte görülmektedir. Doğum travması uterin prolapsusta olduğu gibi rektal prolapsusta da sebep olarak düşünülmelidir. Perineal proktosigmoidektomi rektal prolapsusun cerrahi tedavisinde etkili bir operasyondur. Elli beş yaşında bayan hasta genital bölgede kitle oluşması nedeniyle

kliniğimize başvurdu. İki yıldır kronik konstipasyonu mevcuttu. Pelvik muayenede; total uterin prolapsus, komplet rektal prolapsus ve 3. derece sistosel tespit edildi. Vaginal histerektomi, kolporafi anterior, kolporafi posterior ve perineal proktosigmoidektomi operasyonları yapıldı. Postoperatif 3. günde komplikasyon bir şekilde hasta taburcu edildi. Altemeier (perineal proktosigmoidektomi) komplet rektal prolapsusun cerrahi tedavisinde iyi bir seçenektir.

Anahtar Kelimeler: Rektal prolapsus, Uterin prolapsus, Perineal proktosigmoidektomi

References

1. Watts JD, Rothenberger DA, Bulls JG. The management of procidentia: 30 year experience. *Dis. Colon Rectum*. 1985; 28:96-102.
2. Goligher JC. Prolapse of the rectum. In Nyhus LM, and Condon RE: *Hernia*, 2nd ed. Philadelphia, JB, Lippincott 1978.
3. Altemeier WA, Culbertson WR, Schowengerdt C. Nineteen years experience with the one stage perineal repair of rectal prolapse. *Ann Surg* 1971;173:993-1006.
4. Ajao OG, Adekunle OO. Rectal prolapse in Ibadan, Nigeria. *Trop Doct* 1979;9:117-20.
5. Biehl AG, Ray JE, Gathright JB. Repair of rectal prolapse: Experience with the Ripstein sling. *South Med J*;1978;71:923-5.
6. Boutsis C, Ellis H. The Ivalon sponge-wrap operation for rectal prolapse. *Dis colon rectum* 1965;11:330-8.
7. Efron G. A Simple method of posterior rectopexy for rectal procidentia. *Surg Gynecol Obstet* 1977; 145:75-9.
8. Frykman HM. Abdominal rectopexy and primary sigmoid resection for rectal procidentia. *Am J Surg* 1955;90:780-4.
9. Ripstein CB, Lanter B. Etiology and surgical therapy of massive prolapse of the rectum. *Ann Surg* 1963; 157:259-64.
10. Wells C. New operations for rectal prolapse. *Proc R Soc Med* 1959;52:602-7.
Goligher JC. *Surgery of the anus, rectum and colon*, 4 ed. London, Balliere Tindall, 1980, p 224.
11. Prasad ML, Pearl RK, Abcarian H. Perineal proctectomy, posterior rectopexy, and postanal levator repair for the treatment of rectal prolapse. *Dis Colon Rec* 1986;29:547-552.