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Case Report

Complete Rectal Prolapse. Criteria in the Treatment

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Abstract

Rectal prolapse is not a frequent disease, it is defined as the protrusion of all the rectal layers through anal orifice, it could appear at any age. It is manifested in the patient as a grotesque and cruel form, that usually don't endangers the life and sometimes its chronicity quite long. Nevertheless it represents great symptomatology that is really overwhelming; it could go from total fecal incontinence to totally the opposite, constipation that could end on impactation, as well as bleeding, anal pruritus, odor, and pain. Its etiology is unknown with certainty. The diagnosis is clinical, and its treatment is broad and controverted, with partial success and in some cases even frustrating, given its high recurrence even though in expert hands and/or specialized surgical centers; this represents a challenge that must be specified in each patient depending on how it presents, and, without exception, the unquestionable criteria acquired by experience, knowledge and as well as the Galenical character of the Colon and Rectum Surgeon. It is essential to offer each patient the best, in the ideal moment and when the risk is lower and furthermore to apply the most successful procedure depending what each case requires. This manuscript exposes two different cases with pathology or associated conditions that would modify the usual fashion of treatment and explains the importance of the criteria in the definitive or alternative treatment.

Keywords: *Prolapse; Incontinence; Constipation; Impactation; Controversial; Criteria; Protrusion*

Abbreviation

RP: Rectal Prolapse

Introduction

Rectal prolapse is a disease that fortunately is not frequent; there are accounts on this pathology for the first time on Ebers papyrus 3500 AD. Rectal prolapse occurs at any age, and is more frequent on female sex with a 10:1 relationship. It is defined as the protrusion of all the layers of the rectum through the anal orifice, even today its etiology is unknown [1]. The diagnosis is straightforward and clinical, and its treatment is the objective of this manuscript, given that there are multiple and bread procedures that, even though, they haven't shown the path to take, it is still controversial and must be considered that there must be specified the management for each one of the

cases, not generalizing or classifying it as a gold standard. The basic principle on the management is to correct the prolapse with restoration of the anal-rectal function, sparing secondary effects or lowering this ones as much as possible [2].

Case Presentation

Case 1: 35 years old female, with history of ulcerative colitis, without treatment nor control; 31 weeks of pregnancy with viable fetus. She is admitted to the emergency department with complete rectal prolapse grade III. Anal and abdominal colicky pain, scarce and constant bleeding, mucus and exudate with organ exposition for more than 4 days without any improvement after several attempts to return it to place, incarcerated, with ulcers and amorphous and irregular polypoid tumors grouped of great size. Repetitive events of RP since 4 years before (Figure 1).

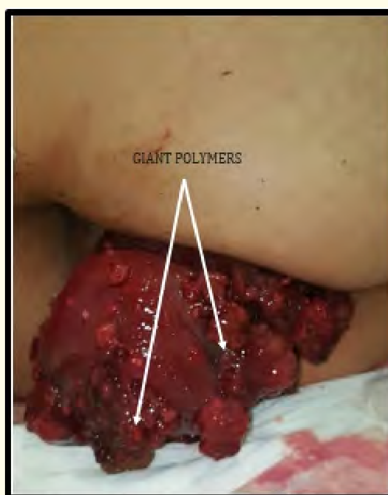

Figure 1: *Rectal prolapse with ulcerative colitis.*

Case 2: 71 year old male with previous maniatic-depressive pathology without treatment, nor control and with a persistent aggressive state; arterial hypertension, ischemic cardiopathy without treatment and social. He was admitted to the emergency department with a RP of 5 days of exposure, incarcerated, without any possible return to place. Scarce rectorrhagia, anal pain and fecal incontinence, mucus and minimal ischemia of the rectal mucosa (Figure 2).

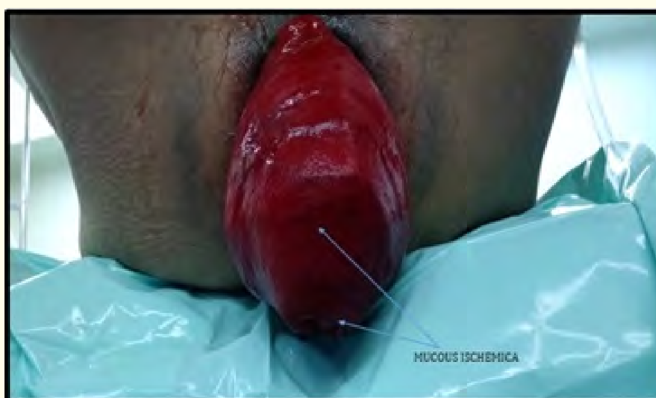

Figure 2: *Complete rectal prolapse.*

Both patients were intervined on a quick fashion with high priority and using Thiersch technique, one of them with local anesthesia (case 1) and in case 2 combined sedation and epidural anesthesia. Both completed successfully and without any complication in modified lithotomy position (Figure 3).

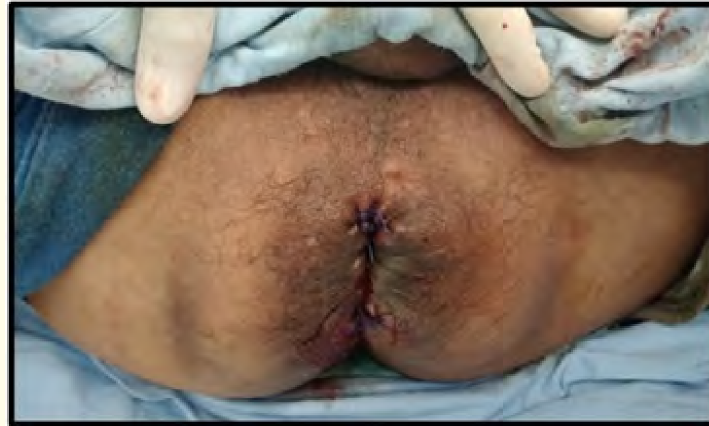

Figure 3: *Thiersch surgery.*

Results and Discussion

Rectal prolapse is a rare entity that requires management with high grade of knowledge and criteria, specifying on each case; without forgetting to correct prolapse and recover the organ function. It is important to mention that there are more than 120 different techniques or with minimal variables that give acceptable results, there are also conservative treatments with more than acceptable results [1]. The surgical treatment of RP can be divided on perianal procedures, which according to some authors is indicated in patients with high morbidity and abdominal procedures on which the laparoscopic technique as referred by experts is the first choice treatment. And lastly nowadays even the endoscopic transanal is establishing as a future alternative [3,4]. It is mentioned that the treatment for RP could be surgical and conservative, nowadays it is different even between surgeons, in each country or region; unfortunately without any consensus, nor accepted protocols universally accepted [4].

It is fair to mention that non-surgical approach that could be considered palliative such as sugar application directly over the prolapsed rectus, and aluminum potassium or diathermy that require multiple applications and its objective is to cause fibrosis on supporting tissues, but they dont represent a definitive action [1]. On the other hand on children the perirectal infiltration with saline fluids 16.5% is used, and even though the glycerine was used previously, both sclerosing agents give curation results in as high as 100% [5].

In case of the surgical treatment of RP, there are a broad number of surgical procedures in adults, in which each case could be individualized or specified regarding the conduct to follow; it is common that the perianal technique used on the emergency room for incarceration, necrosis or uncontrolled organ bleeding is the Altemeier technique [6]. Furthermore there are other surgical techniques such as Delorme that consists in resection of the mucosa and submucosa of 10 - 12 cm with muscular plane plication. Both techniques are as well ideal on patients with ASA III-IV or high surgical risk. With a recurrence of 14% for Altemeier and 16% for Delorme; with complication rate of 22 and 7% respectively [7]. On these we also include the anal Thiersch procedure, and also perineal fixation and suspension of Wyatt between much more [1,8].

The RP approach via laparoscopy or conventional are the surgical procedures with more acceptance. I think via laparoscopy is the best access to operate a rectocele by abdominal way. Given the efficacy of ventral laparoscopic rectopexy with or without mesh [9], vental

laparoscopic rectopexia [10], and the Frykman-Goldberg rectopexia included sigmoidectomy. All of them with a recurrence rate of 20-30% on surgical perineal procedures that round 50% as a maximal range, and with morbidity of 0-17% null mortality on the abdominal procedures and unto 15% of recurrence; morbidity with 0-32% rate and 4% mortality rate [11,12].

The authors of this manuscript combined the strengths of each surgical technique and fuse them on one alone, the redundant sigmoid colon resection with rectopexia with Frykman-Goldberg technique is realized and a prosthetic mesh such as Ripstein surgery is used, but in the posterior portion of the rectum, once movilized with separated sutures in U shape of polypropylene #1, from sacrum that pass through the mesh and then to the rectum; movilization of the rectum is followed by Curae technique and lastly anterior fixation with Pemberton technique is performed. We have operated 12 patients with follow up of 6 years without recurrence, nor complications and rehabilitated anorectal physiology.

Conclusion

The Thiersch surgical technique, is widely described on medical literature, which allows control of concomitant pathologies of greater importance which endanger the patients life; protected on a integral view of the patient, rehabilitating, and improving conditions, diminishing the surgical risk to realize with ethic, efficiency and efficacy the definitive surgical procedure in case of recurrence.

To think that the criteria or decision of the surgeon of the surgical technique to perform is essential, this depends on each patient, given them the experience and knowledge of the surgical staff will have to focus on the premise of not harming but healing, with the objective of offering the best prognosis for the patient.

Disclosure of Interests

Authors declare that there are not any conflict of interest or financial interest on the current paper.

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