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Case Report

Rectal Prolapse: Is All-In a Good Option? A Case Report

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Abstract

Rectal prolapse is defined as the protrusion of full thickness rectal wall through the anal canal. It is a debilitating pelvic floor disorder and significantly impairs quality of life. The sole curative treatment is surgery that should be tailored according to the patient characteristics, comorbidities and to the risk of post-operative complications. We aimed to present a case of a large rectal prolapse that was treated with an abdominoperineal resection.

A 57-year-old male, with membranous nephropathy, was evaluated due to a large and irreducible prolapse. A Thiersch procedure was performed as a temporary treatment until definitive treatment was planned. Due to the hypotonicity of the anal sphincter, the lack of sensitivity in the anal area, the extension of the prolapse, the need for a temporary procedure to reduce it, combined with his immunosuppression, we chose to perform a trans sphincteric abdominoperineal resection. The postoperative period went without any complications.

The rectal prolapse should be operated as soon as the diagnosis is confirmed. Surgical options include abdominal and perineal approaches. Choosing the surgical approach depends on the patient's characteristics and on the surgical team's experience.

Surgeons should always consider pre-operative testing and planning, as well as postoperative complications, to determine whether the patient is a surgical candidate and which is the best approach. This case strengthens the abdominoperineal resection as a valuable option in the management of rectal prolapses and when it should be considered.

Keywords: Rectal diseases; Rectal prolapse; Proctectomy

Introduction

Rectal prolapse is a debilitating pelvic floor disorder that significantly impairs quality of life. It can manifest in a variety of ways and a wide range of symptoms, such as protruding mucosa, pain, bloody and/or mucous rectal discharge, incomplete evacuation, fecal incontinence or constipation [1-4]. It is more prevalent in women than in men, and in those over the age of 50 [3]. Risk factors for rectal prolapse include constipation, multiparity, previous surgery, neurologic diseases, connective tissue disorders and pelvic floor abnormalities [5,6]. Internal rectal prolapse and external rectal prolapse, also known as rectal intussusception, are two different types of rectal prolapse [3]. Complete external rectal prolapse is defined by a circumferential, full-thickness rectal protrusion through the anus, which can be intermittent or can become incarcerated and poses a danger of strangulation [1]. Conservative treatment options can include behavioural changes and biofeedback of the pelvic floor. However, surgery is the sole curative option intended to improve bowel function and quality of life [7-9]. Rectal prolapse can be repaired via the abdomen or perineum, with a variety of options described for both [10]. In this article, we report the case of a male with rectal prolapse who underwent the Thiersch procedure prior to an abdominoperineal resection, and we discuss the possible treatment approaches based on current literature.

Case Presentation

A 57-year-old male patient, with medical history of membranous nephropathy, hypertension and dyslipidemia, was admitted to our institution due to the worsening of nephrotic syndrome. During the admission, he presented with rectal prolapse, and a surgical consultation was required. He had a past history of rectal prolapse for several years, confirmed by a colonoscopy, as well as a normal colonic transit exam. Upon physical examination, the man presented with a complete rectal prolapse measuring more than 15 cm in length and an edematous, ulcerated mucosa, indicative of a grade 4 rectal prolapse (Figure 1).

The anal sphincter exhibited hypotonicity, assessed during a rectal examination, with a total absence of sphincter tone at rest or during contraction, along with high compliance and a lack of sensitivity in

Figure 1: Complete Rectal Prolapse.

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the anal area. Therefore, a perianal approach was proposed, but was postponed due to his poorly controlled nephropathy. Four attempts at reduction were performed with immediate recurrence. At this time, epidural analgesia was administered due to poorly controlled pain. Following the failure of external manual reduction, we decided to perform the Thiersch procedure as a temporary treatment until definitive treatment was planned (Figure 2).

Figure 2: Surgical Wound from The Thiersch Procedure.

This procedure involved subcutaneous tunnelling around the sphincter and the insertion of a 16 Fr siliconized urinary catheter, followed by calibration and fixation with silk in the left lateral incision.

Given the hypotonicity of the anal sphincter, the lack of sensitivity in the anal area, the extent of the prolapse, the need for a temporary procedure to reduce it, his immunosuppression and the patient's preference for having a stoma rather than becoming incontinent, we determined that the Delorme or Altemeier procedures would not be successful. Instead, we opted for a more radical and more successful procedure - a trans sphincteric abdominoperineal resection. The surgery began with an abdominal approach, using an open technique through a midline incision. The colon was sectioned to create a colostomy. The parietal layer of the rectal peritoneum was dissected with the opening of the Douglas pouch, followed by the dissection of the presacral fascia, with preservation of the hypogastric plexus, mesorectum, the seminal vesicles and prostate, extending down to the elevator ani muscles. The perineal approach involved a circumferential trans sphincteric dissection with inversion of the specimen and its excision.

The postoperative recovery was uneventful and the patient was discharged on the sixth day. Histopathological analysis revealed a small hyperplastic polyp in the rectal mucosa, with no other discernible morphological alterations. Four months later, the patient has fully adapted to the colostomy and reports an improved quality of life.

Discussion

Surgical repair is the preferred and the only potentially curative treatment for the vast majority of rectal prolapses. Exceptions include patients that are poor operative candidates or choose to avoid a surgical approach. Nevertheless, medical management is paramount either as solo treatment or combined with surgery. Improving lifestyle habits, such as maintaining adequate fluid and fiber intake, engaging in regular physical exercise, treatment of constipation, and pelvic floor exercises, play a crucial role in minimizing symptoms, preventing disease progression, and the success of these patients [1,4,5,7,8,11].

When the rectal prolapse is external or when an internal prolapse becomes symptomatic, earlier surgical repair is desirable. The main goals of rectal prolapse surgery are to alleviate the symptoms, including fecal incontinence or constipation and to correct the prolapse [2,4,5,7,8,10-13].

As the prolapse progresses, the symptoms worsen over time, the sphincter complex becomes weaker, there is risk of incarceration and strangulation, and therefore a surgical emergency.

Surgical options include abdominal and perineal approaches. Abdominal approaches can be performed as open surgery, laparoscopically, or robotically. Abdominal rectopexy procedures, such as those by Ripstein (anterior rectopexy), Wells (posterior rectopexy), Loygue or (laterorectal), are suitable for physically fit younger candidates [1-5,7-14]. If the patient has pre-existing constipation, a sigmoid resection can be performed in association [1-3,7,10-12].

The perineal approaches normally include either the Delorme procedure or the Altemeier procedure. These procedures are traditionally reserved for patients considered medically unfit for abdominal surgery, generally old and frail individuals, with comorbid illnesses, or that underwent previous transabdominal repair [1,3,5,7,10-13]. The Altemeier procedure, also known as perineal proctosigmoidectomy, is typically performed in rectal prolapse with a length greater than 3 cm [1]. The Delorme procedure is usually performed when the prolapse is shorter, because the proctosigmoidectomy is technically difficult. However, both of these procedures have higher recurrence rates, that can vary between 9% and 30% [4,5,7,9,11-13]. An anal encircling procedure to stop the prolapse can be done, in some patients that are unfit, such as the Thiersch procedure that was performed in our patient [10].

Rectal prolapse symptoms can appear in a variety of ways; thus, no single treatment plan is appropriate for all patients. Because of this, it's critical to comprehend each patient's etiology, anatomy, and general health in order to personalize the therapeutic strategy [1,7,10,13].

In our case, the patient was submitted to an abdominoperineal resection that, due to the grade of hypotonicity of his anal sphincter and his health comorbidities, was considered to be the best option, by both the patient and his doctors (surgeon and nephrologist). Even though this surgery is associated impaired quality of life due to the permanent colostomy, a recent study shows that an important proportion of patients, owing to the impairments in anorectal function associated with sphincter preservation, would prefer abdominoperineal resection over sphincter preservation [15].

Post-operative problems, such as fecal incontinence, constipation and recurrence of the prolapse, should be considered when determining an operative approach, as the patient's overall state of health and informed decision.

Conclusion

Rectal prolapse has a negative impact on quality of life. A tailored surgical strategy is needed for patients suffering from this disease. Post-operative problems should always be considered when determining an operative approach. Therefore, appropriate pre-operative testing and planning is essential to determine whether they are a surgical candidate and which is the best approach. This case strengthens the abdominoperineal resection as a valuable option in the management of rectal prolapses.

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