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Living with Huge Rectal Prolapse and Rectocele: A Sad Story of a Rural Nepalese Woman

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ABSTRACT

A postmenopausal multiparous woman with defecation difficulty for over three and half years upon clinical examination was diagnosed as a case of huge rectal prolapse with rectocele during a health camp organized by the Perinatal Society of Nepal in Sindhupalchok. She was referred to a tertiary care center so that she could undergo combined corrective surgery in the same sitting: rectal prolapse by Surgeons and rectocele by Gynecologists. Unfortunately, she was returned home with a scheduled elective operative appointment a few months later, which she failed to make owing to the long distance from home to hospital. Her case could not be followed, as the contact number she left was unreachable. This case represents an example for many women who have to live with suffering, their problems overlooked by both families and institutions, a situation in dire need of a solution.

Keywords: *Defecation; Rectocele; Rectal Prolapse*

INTRODUCTION

Rectal mucosal prolapse is a true intussusception of the viscus outside of the anus, through the sphincters characterized by the protrusion of the mucosa or full-thickness layer of the rectal tissue through the anal orifice diagnosed on physical examination or by making the patient strain as if to defecate.

Significant rectocele is defined as herniation of the anterior rectal wall seen as a bulge, more than 20 mm in diameter over posterior vaginal wall due to the loss of the rectovaginal septum.[1] Rectocele detected in 17 (13.7%) of 124 external rectal prolapses (ERP) shows a frequent association of both the conditions.[2]

A case of concomitant rectal prolapse and rectocele diagnosed at a health camp and referred for surgery at a tertiary care center is described herewith.

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CASE REPORT

At a health camp organized by the Perinatal Society of Nepal (PESON) in Sindhupalchok on 22nd November 2014, a 59-year-old postmenopausal multiparous woman came with a complaint of debilitating symptoms of obstructed defecation, pelvic pain, fecal incontinence, and occasional soiling of clothes with mucous, feces and blood for 3½ years. On examination, the general condition was fair; no pallor, icterus, or edema. She was normotensive. On systemic examination, chest and CVS were normal. The abdominal findings showed no mass or hernia. On per vaginal inspection, a sizeable rectal prolapse, a simple bowel with mainly concentric symmetric folds was detected measuring approximately 10-12 cm (Fig 1a, Fig 1b) stretching the rectocele downwards. A thumb was inserted in the lumen of the prolapsed bowel and the first and second fingers on the external aspect, firmly grasping the bowel wall, the full thickness/ double thickness of the prolapsing bowel confirming rectal procidentia, which on gentle pressure was squeezable and could be repositioned.

She and her family members were counseled for surgical remedy thereby referring her to one of the tertiary care hospitals in Kathmandu with a request for admission and operation. She attended Gynecology/ Surgical outpatient clinic and returned home after receiving the date for surgery. She did not report for her operation and was lost to follow up.

***Figure 1a**: Rectocele with Rectal Prolapse*

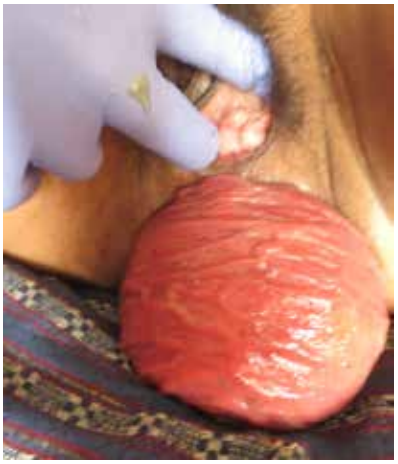

***Figure 1b**: Rectocele with Rectal Prolapse*

DISCUSSION

This is a case of huge complete rectal prolapse, close to the size of 10-12 cm in association with rectocele in elderly multiparous postmenopausal women mandating surgical correction aiming to restore continence and prevent constipation or impaired evacuation.

Comparing perineal and abdominal operations, rectopexy alone, resection alone, and/ or resection plus rectopexy are routine procedures. Different techniques such as Tiersch operation: encircling the anus with wire originally modified by silicone, mesh, silastic rings, or Angelchik prosthesis; or plicate or resect the prolapse, or to suspend and/or fix it or to wrap with foreign material have emerged.

The perineal approach is the preferred non-invasive procedure for high-risk elderly unfit for other more invasive procedures or in the rectal prolapse up to 6–7 cm with bowel incarceration or necrosis.

Delorme's or Delorme plus levatorplasty / Altemeier's Operation; former performed externally involving the rectal mucosal mucosectomy or stripping with rectal wall muscle plication, the latter employs a perineal sigmoid colon-rectal resection (rectosigmoidectomy).

Abdominal approach for rectal prolapse correction undertaken via laparotomic /laparoscopic/ robot-assisted means seldom involves

rectosigmoid resection with colorectal anastomosis with or without rectopexy. Delorme's or Delorme plus levatorplasty /Altemeier's Operation; former performed externally involving the rectal mucosal mucosectomy or stripping with rectal wall muscle plication, the latter employs a perineal sigmoid colon-rectal resection (rectosigmoidectomy).

Abdominal approach for rectal prolapse correction undertaken via laparotomic /laparoscopic/ robot-assisted means seldom involves rectosigmoid resection with colorectal anastomosis with or without rectopexy. Rectopexy confers dissection of rectum thus employing various material such as absorbable/non-absorbable suture preferably mesh of foreign material such as "Vypro" positioned on (anterior, posterior) aspect of the rectum with (posterior or lateral) fixation safely suspending to the sacrum, Ventral Mesh Rectopexy (VMR) being a procedure of choice.[3]

Rectal prolapse when complicated by uterine prolapse or rectocele, Gynaecologists first perform pelvic floor repair with/without vaginal hysterectomy following which Surgeons then complete the correction of rectal prolapse. An abdominal approach is mandatory for huge rectal prolapse measuring 10–15 cm like our case with colpoperineorraphy or rectocele repair.

Health camps in Nepal play an important role, as medical and surgical teams can periodically examine those patients who may be unaware that they need urgent medical attention and at the very least provide basic minor services, grant correct medical advice including referrals, and point rural patients in the right direction regarding their health issues. Of equal importance is the bond created by hospitals in towns and cities with health camps in remote areas. Such health camps organized routinely attempt to link patients initially observed in health camps to the hospitals, creating a familiarity between doctors and patients so that patients sick enough to warrant intensive and specialized care will receive treatment in well-equipped and staffed medical centers. Rural patients feel comfortable enough to divulge intimate details about their pressing health issues to doctors under such conditions of familiarity. This bond created by routine visits, even though temporary, poses great benefits to both patients as well as doctors who gain precious experience and insight into patient diagnoses.

On the contrary, this was not so in our case and regrettably this village woman with a prolonged history of suffering, despite being referred to the tertiary care center for admission and operation was asked to come for surgery later. It is, therefore, imperative for one and all health service providers to be apprised of the critical implications of a patient's long-distance journey, financial constraints, in addition to the reluctance of families to accompany their elderly relatives. We may never know if a patient will return for follow-up appointments, in some cases as vital as surgery described here. It is understood that rural Nepalese women burdened with low socioeconomic status live a compromised life in adversity, silently suffering the consequences of concomitant rectal prolapse and rectocele for prolonged periods. The question remains if this should persist. Such conditions go untreated due to a variety of factors. Lack of awareness of the seriousness of the disease, which in this case of rectal prolapse if left untreated possibly could be complicated mainly by bleeding from ulceration of prolapsed rectum, strangulation, and gangrene. Shyness, preference for waiting out for female doctors, and their lack in remote areas, tolerating the pain until unbearable; are the contributing factors and they need not be the norm.

CONCLUSION

Provisions for health education ensure health-seeking behavior must be balanced by prompt quality health services. Such that a woman with significant rectal prolapse or rectocele or both together in need of surgery referred from health camp to a tertiary care center is duly admitted operated and happily goes home and does not have to come back for treatment again from far away distances.

CONFLICT OF INTEREST
None

SOURCES OF FUNDING
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