

CASE REPORTS

## Complete rectal prolapse in adults: a Tanzanian experience

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### SUMMARY

This is a retrospective report of nine patients with complete rectal prolapse managed by the authors at the Muhimbili Medical Centre, Dar es Salaam between 1990 and 1993. The average age of patients was 36 years and eight of the patients were males. Six of the patients presented as emergency admissions of whom three had irreducibility and required perineal proctosigmoidectomy. This was the procedure of choice for irreducible complete rectal prolapse.

### INTRODUCTION

Rectal prolapse in adults is not a common problem and is reported as predominantly a disease of the elderly female.<sup>1</sup> It is a disabling surgical condition with considerable controversy regarding its management and one that has fascinated surgeons for a long time.<sup>2</sup> Actual rectal prolapse occurring in a healthy young man, eventually leading to gangrene and requiring emergency surgery must be considered rather rare. It should therefore not be surprising that many a surgeon would be unfamiliar with its management.

In 1990, a previously healthy young man presented with a sudden massive prolapse that was irreducible. Over the next four days he was managed conservatively until he developed gangrene. An urgent perineal proctosigmoidectomy was then performed. This initial case prompted the authors to study the pattern of rectal prolapse seen at Muhimbili Medical Centre and report the salient features.

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### MATERIALS AND METHODS

All adult patients admitted to hospital with complete rectal prolapse between 1990 and 1993 were seen by the authors and managed accordingly. Those in whom manual reduction was achieved were managed by a Thiersch procedure with a view to performing a definitive procedure at a later date. Those in whom manual reduction was either unsuccessful or not possible due to local factors were managed by perineal proctosigmoidectomy. Local factors which contra-indicated manual reduction included evidence of local necrosis and massive oedema. Three cases were admitted with uncomplicated prolapse and were managed electively.

#### Perineal Proctosigmoidectomy

The procedure is performed under general anaesthesia with the patient in lithotomy position; and an indwelling urethral catheter *in situ*. Four stay sutures are placed one anteriorly, one posteriorly and one on the other side, laterally. A semi-circular incision is made two cm from the anal verge beyond the stay sutures and this is gradually deepened with careful haemostasis being observed as the rectal wall is usually oedematous and vascular. The incision is deepened until it goes through the bowel wall and the sigmoid colon is exposed. The incision is then complete circumferentially. The mesentery of the sigmoid colon is clamped and transfixed by sutures. The sigmoid colon is then pulled downwards until it can come down no more, and it is divided two cm outside the anus, again after stay sutures corresponding to those on the other outer rectal cuff are applied.

Anastomosis is then performed by interrupted silk 2/0 sutures as a single layer between the outer and inner cuff using the stay sutures to approximate the edges. The rectal cuff is then gently pushed back through the anal canal, and a sofra-tulle dressing on a gauze pad is left in place.

### RESULTS

There were a total of nine patients with rectal prolapse seen over a three year period. Three had reducible rectal prolapse while six were seen with irreducible prolapse requiring emergency surgery. There were eight males and only one female. Their aged ranged from 21 years to 70 years but the majority of patients were young being between 21 and 40 years of age. The only female was the oldest patient at 70 years.