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Review Article

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SMALL BOWEL EVISCERATION THROUGH THE ANUS: A RARE PRESENTATION IN RECTAL PROLAPSE

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ABSTRACT

Evisceration of the small intestine through the anus is a rare presentation in emergency. We reported a case of 60 year female with history of recurrent rectal prolapsed aggravated during the act of defecation followed by self reduction. Patient presented in emergency OPD of department of general surgery IGMC Shimla with small bowel protruding out through anus. Patient admitted and emergency operation was done and reduction of healthy looking small bowel and repair of tear present on anterior wall of the rectum was done. on POD-7 bile tinged fluid came in drains, reexploration done and resection of gangrenous segment with exteriorization of both the end of bowel done, subsequently patient operated third time to maintain bowel continuity after 2 month.

INTRODUCTION

Evisceration of the small intestine through the anus is a rare presentation in emergency. Spontaneous rupture of the colon or rectum is also a very rare event. Perforated complete rectal prolapse and small bowel lying outside anus become extremely rare condition. Spontaneous perforation has been reported in elderly patients with chronic constipation, colonic and rectal malignancy. Presentation is with acute severe abdominal pain usually following the intake of laxatives for chronic constipation, with or without signs of peritoneal irritation. Spontaneous perforation of the colon or rectum is seen as a complication of various pathological conditions such as diverticular disease, carcinoma, colitis, blunt or penetrating trauma and injury from faculty instrumentation. Protrusion of several loops of the small bowel through anal orifice through colonic, rectosigmoid or rectum perforation is a very rare presentation.

CASE REPORT

A 60-year-old woman was admitted in the department of surgery, IGMC Shimla with a history of rectal prolapse which was aggravated during the act of defection and followed by self reduction. The patient was almost fit prior to this event and never consulted a doctor. The patient noticed loops of bowels through the anus when she tried to strain while defecating and reached the hospital 8 hours after this event along with pain abdomen, abdominal distention and history of multiple episodes of non-bilious vomiting. There was no history of rectal trauma. At the time of admission patient was pale, in low general condition with pulse rate of 92/min, blood pressure 134/78 mm and spo2 -98% on O2.

On Examination

P/A: soft, diffuse tenderness present, no guarding or rigidity. About 3 meters of small gut was lying outside the anal canal with mesentery and serosa , and was pale coloured in 1/3 segment with pre gangrenous changes in rest of gut which was lying outside (figure 1).

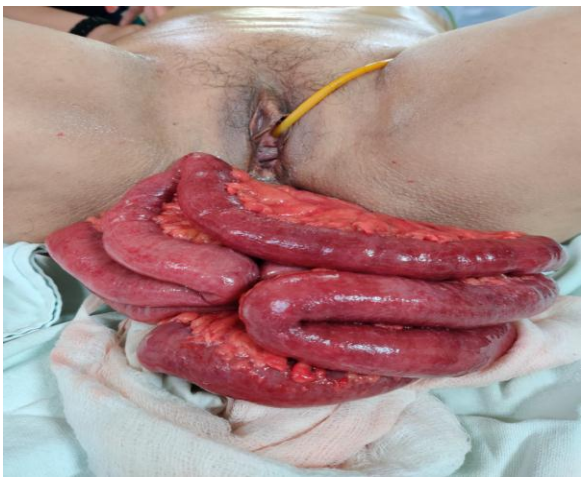

Fig 1: Clinical Picture Showing Small Bowel Prolapse From Anus.

Fig 2: Intraoperatively After Small Bowel Reposition.

Management

Patient was immediately admitted, resuscitated and planned for emergency surgery.

Surgery

OPERATION 1: Exploratory laparotomy with reduction of prolapsed gut with primary repair of anterior rectal wall perforation with sigmoid loop colostomy with PT/PD done. Per-operatively prolapsed gut was 15cm from duodenojejunal junction upto ileaoceacal junction with pregangrenous changes. Prolapsed gut was reduced (fig.3), viability of gut was ensured by looking for peristalsis, mesenteric pulsations and normal colour of gut. A perforation of 8cm in anterior wall of rectum 7cm from anal verge was primarily repaired. On POD-7 drain output was 30cc bile tinged with suspicion of bile leak (biliary peritonitis) kept and patient taken for re-exploration.

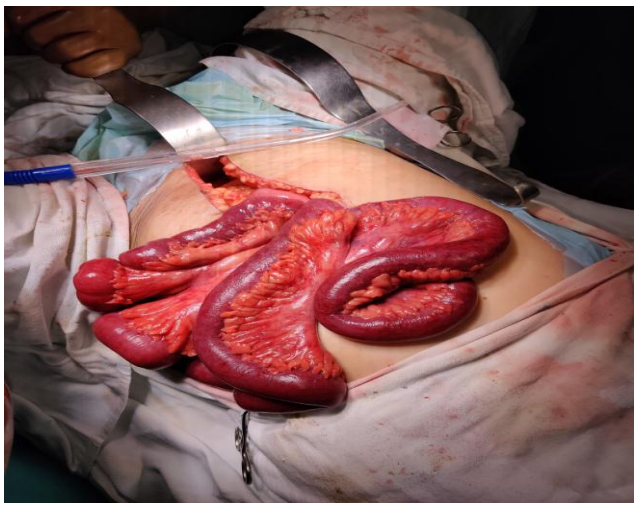

Fig 3: Reduced gut loops.

OPERATION 2: Exploratory laparotomy with resection and anastomosis of gangrene and perforation bearing segment of jejunum and ileum with peritoneal toileting and drainage done. On opening abdomen, frank faeculent material around 1 litre was drained. Around 105cm long segment of jejunum and proximal ileum was gangrenous on anti-mesenteric border with perforation in proximal jejunum. Resection and anastomosis done with exteriorising of anastomosis bearing segment done.patient built up with protein rich diet.After 2 month third operation done to maintain bowel continuity and patient servived.

DISCUSSION

The small bowel evisceration through the anus is very rare. Brodie was first to describe the condition in 1827. After him, there are very few cases reported in the literature. Usually this type of evisceration occurs in a prolapsed rectosigmoid colon. Increased intra-abdominal pressure is usually the precipitating factor. The relationship between a rectal prolapse and a spontaneous perforation in its wall has been poorly understood. Most acceptable pathophysiology seems to be a rectal prolapse in the form of a 'sliding hernia' in the Pouch of Douglas and the contained viscera form the hernia sac. The hernia sac invaginate the anterior wall of the rectum into the rectal lumen and it usually happens at the anti-mesenteric border. This repeat insult to the wall results in ischemia at the local site along with weakening. Increased intra-abdominal pressure which is the cause for a prolapse may also be responsible for the perforation of weak portion of a rectosigmoid wall. Other possible causes may include chronic decubitus ulcer in prolapsed rectum secondary to pressure necrosis. The basic principle of management in such case should be like any emergency abdominal case. First adequate resuscitation should be performed and hot moist mops should be applied on the exposed bowel. Emergency surgery under general anaesthesia should be carried out with the aim of exploration. The bowel is repositioned in the peritoneal cavity and perforation is identified. The extruded small intestine should be checked for viability. The perforated area may be repaired at the same time or after some interval by creating temporary colostomy depending on the condition of the patient. This rare condition can be prevented by elimination of precipitating events, such as rectal prolapse and avoidance of conditions which heads to increased intra-abdominal pressure.

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