CONGENITAL RECTAL PROLAPSE :A CASE REPORT

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***Abstract*- Rectal prolapse is a condition which can be managed both conservatively if asymptomatic but usually requires surgical intervention to correct. Traditionally we are using abdominal and perineal approaches but recently laparoscopic techniques have shown excellent outcomes and is as effective and equivalent to traditional techniques.**

***Keywords:* Rectal prolapse, laparoscopic trans-anal sutured rectopexy, laparoscopic ventral mesh rectopexy ,Delorme procedure, Altemeier procedure.**

Introduction:
Rectal prolapse is a circumferential prolapse of rectal wall through the anus. This condition is socially embarrassing and person debilitating . More common in females after child birth but can occur in males doing excessive straining.It may be mucosal prolapse or full thickness prolapse. Symptoms may include continuous mucus secretion, pain ,bleeding, chronic constipation, fecal incontinence .In adults surgery is almost necessary and different approaches are used. Recently minimally invasive laparoscopic rectal rectopexy is introduced and shows excellent outcomes with early post operative recovery.[1[,[2],[3]

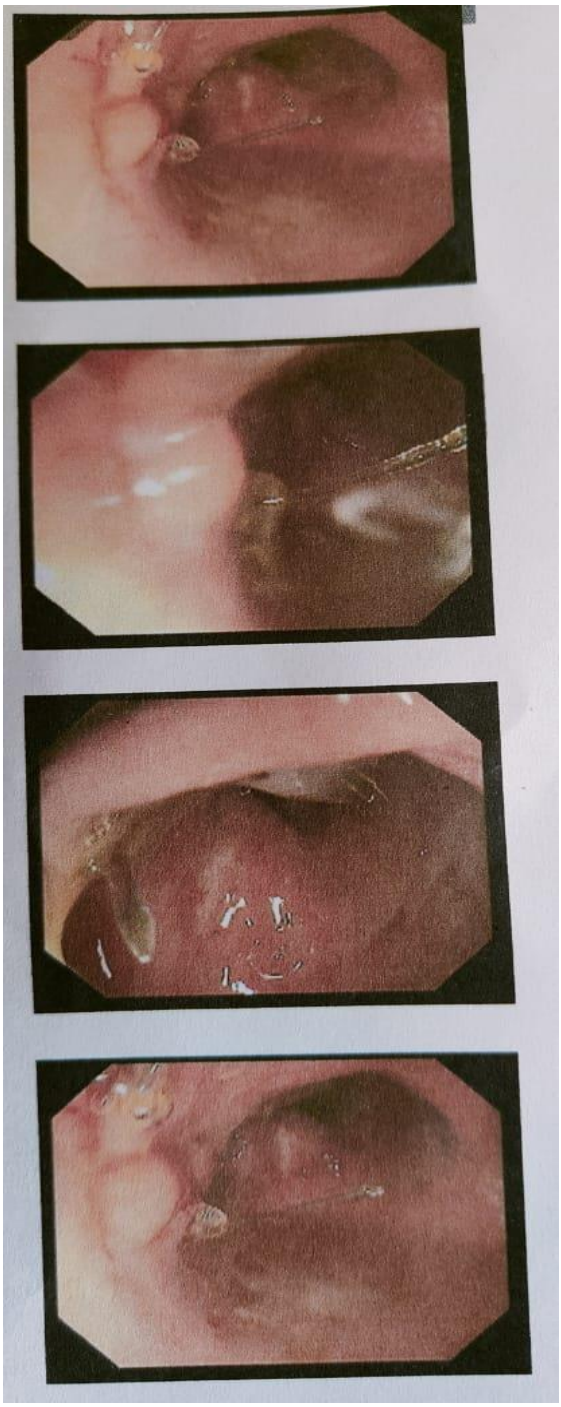
Case report:
We report the instance of 23 year unmarried female presents with complain of something coming out of anus since birth with constipation and pain with bleeding per rectally since one week.no history of pregnancy or any pelvic trauma noted .Per rectal examination shows 2 cm rectum comes out only on straining .MRI pelvis shows ano-rectal junction is lying 3.5 cm below pubo-coccygeal line. Patient was planned for laparoscopic trans-anal posterior wall rectopexy. Blood indices and electrolytes were in normal range. Colonoscopy revealed normal bowel loops
Under spinal anesthesia in lithotomy position painting and draping was done. Chivate's proctoscope was interted .Poly dioxanone suture is taken in laparoscopic needle holder and stiches were taken in gap of chivate's proctoscope. Six interrupted sutures taken vertically and posterior rectal wall is fixed with sacrum. Post operative laxatives and kegel exercise were instructed and follow up colonoscopy done after 1 month.

Discussion:
The purpose to treat prolapse is to eliminate prolapse, correct associated incontinence or constipation and prevent further bowel dysfunction. Both abdominal or transanal approach can be chosen.
The first method is suture rectopexy through abdominal approach where complete mobilization of rectum upto level of levator ani muscle. Then sutures or staplers are used to secure rectum to sacral promontory. New onset constipation reported in 0-40% and recurrence in 12% within 1 year postoperatively.[4]
The second method is posterior mesh rectopexy. After the rectum is fully mobilized, a mesh is inserted between the sacrum and the posterior rectum, sutured to the rectum, and secured to the promontory. The mortality rates ranged from 0% to 1.2%[5][6], and the recurrence rates ranged from 0% to 4%. New-onset constipation has been reported in 5%-44% of patients[7]. The third method is ventral mesh rectopexy. Dissection is anterior to the rectum, preserving the lateral ligaments, and the rectovaginal septum is dissected to the pelvic floor, avoiding mobilization of the mid rectum. The rectum is attached to the sacrum by a mesh sutured as distally as possible to the anterior side of the rectum. This procedure preserves the autonomic nerves and improves constipation in most patients. Newly developed constipation was found in 0%-6% of patients[8]
Postoperative constipation is an important functional problem frequently encountered after a rectopexy procedure. The exact mechanism of constipation after rectal fixation remains unclear, but several factors have been suggested to contribute to this phenomenon. Redundant or twisted sigmoid colons can cause delayed transport and cause functional obstruction. In addition, constipation may occur because of nerve injury during full mobilization .In our case as bowel are normal we choose minimal invasive procedure through transanal route and no anastomosis is required. We just fix

the posterior wall of rectum to sacrum by sutures .After 1 month follow up patient has no complains of constipation and no recurrence noted.

CONCLUSION:

Tradional methods are no longer used now .Laparoscopic methods also has some side-effects causing damage to autonomic nerves or post operative constipation and there is always some risk when to create anastomotic site. Therefore Trans anal posterior wall rectopexy is a minimally invasive procedure without much alteration in bowel anatomy and can be performed in future where ever feasible as post- operative results are also excellent



Poly-diaxonone sutures seen on sigmoidoscopy done after 1 month post-operative.

After 1 month post operative clinical picture while straining

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