Case report

Concomitant rectal and uterovaginal prolapse in the community

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Introduction: Concurrent occurrence of rectal and uterovaginal prolapse in many women living in the community with misery should be made aware that there is possible solution to this dual debilitating condition by surgical correction which can be acquired at the same sitting to bring changes in their quality of life.
Case Report: We report here two ceses of concomitant rectal and uterovaginal prolapse.

Introduction

It is learnt that women suffer from rectal prolapse alone as they do from genital prolapse but both of these conditions concurrently occurring was found to be less than 100 after making compilation from various study. The largest number of the cases amounting to 55 in one of the series followed by small numbers like 17, 10 cases and a case report each. [1-6] In fact rectal prolapse has been observed to affect women suffering also from other forms of pelvic floor deficiencies.[3] An important observation that can be cited here, is a study which found 55 cases of rectal prolapse associated with other forms of pelvic floor deficiencies in 52 cases. But the reverse does not hold true as very few women with uterovaginal prolapse are actually seen to be associated with rectal prolapse.[2]
Here are two cases of rectal prolapse associated with uterovaginal prolapse seen recently at the rural health camp, thus addressing the multidisciplinary awareness of an effective solution to this debilitating problem appropriately by joint surgical approach that is feasible.

Case 1

A 42 year old multipara P6, with all living children came to us at the reproductive health camp in Dadeldhura with the history of something coming down per vagina and difficulty in holding the stool for almost the past 10 years. There was history of uterovaginal prolapse since the home delivery of her first child 25 years ago. And all other subsequent births followed the same pattern, taking place at home. She had not taken any form of treatment for this problem all these years and there was no history of insertion of ring pessary that is often a usual solution to this problem and is provided freely in rural health camp as a temporary remedy to support

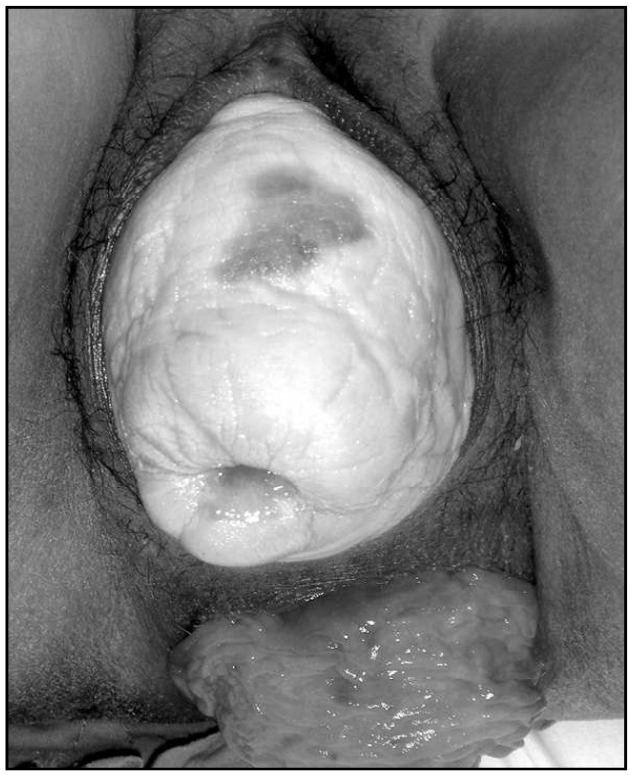

Fig 1. Uterovaginal prolapse associated with rectal prolapse

prolapsed uterus. She was a smoker with history of chronic cough and while inserting the ring pessary for third degree uterovaginal prolapse 'procidentia' a huge rectal prolapse *(Fig. 1)* was seen, the stool was smeared all over in the genitalia. We inserted a 3-inch size ring pessary *(Fig. 2)* and asked her to undergo operative management for both of the conditions simultaneously.

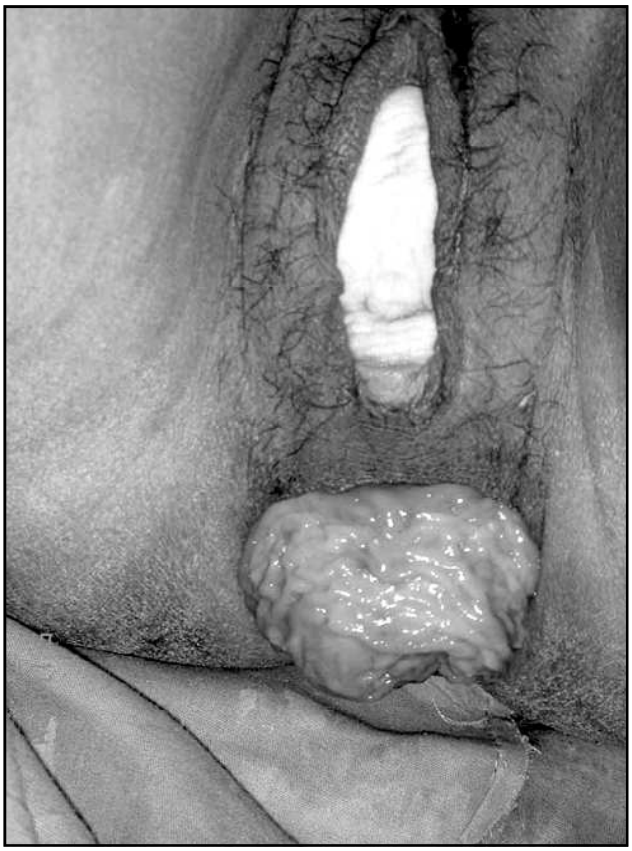

Fig 2. Rectal prolapse after the insertion of ring pessary.

Case 2

A post menopausal grandmultipara came to the general health camp conducted by Nepalganj Medical College in Dadeldhura (parallel to the Reproductive Health Camp we were carrying at the same time) with history of uterine prolapse for 40 years, since the early puerperium of her first birth. She was in fact habituated with the prolapsed uterus but was bothered by the mass coming per rectum for sometime which made her life miserable as she was not able to hold the stool. There was no history of diarrhoea in the past. Examination revealed a huge genital prolapse with complete eversion of the vagina, (procidentia with rectocele and cystocele) along with the rectal prolapse *(Fig. 3)*. She too was advised to undergo combined surgery at Nepalganj Medical College.

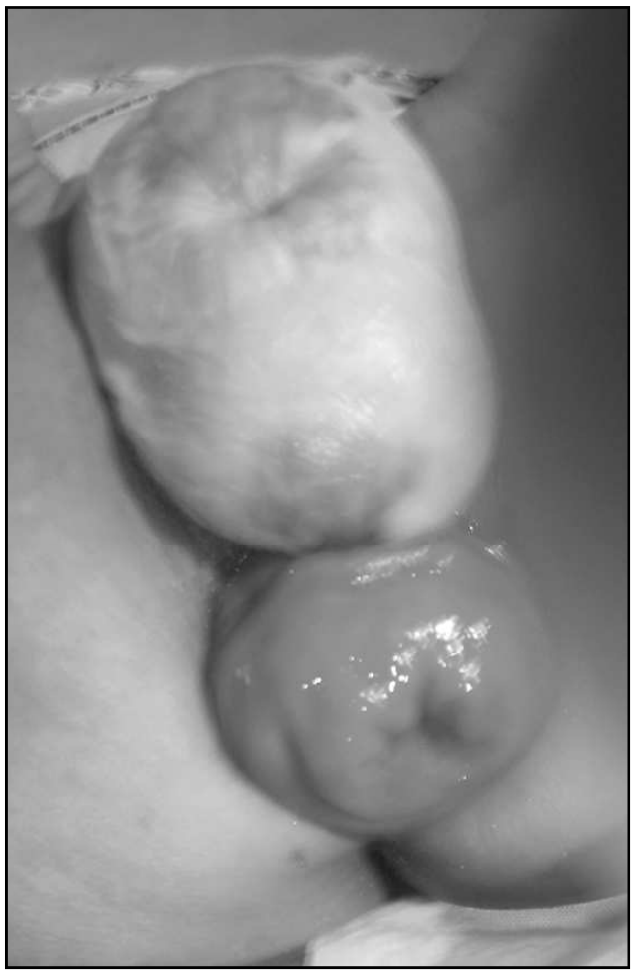

Fig 3. Uterovaginal prolapse associated with rectal prolapse.

Discussion

Fewer than 100 cases of concomitant genital and rectal prolapse have been reported. While two of them are described above, with not less than 10 or more of such cases evident only in Dadeldhura, where this combined genital and rectal prolapse were found to occur in larger numbers compared to the other regions of Nepal like Dang and Baglung where similar reproductive health camps were also held.

This too indicated that, whenever there was rectal prolapse one could expect genital prolapse to coexist invariably whereas the vice versa did not seem most likely, meaning we hardly find genital prolapse to be associated with rectal prolapse.

Most surprising part is the fact that, these women were so well adjusted to their life style even when they were suffering for more than a decade and were hardly bothered to avail any surgical interventions for the remedy from these

conjoint problems, in the pretext that they had to look after the domestic cattle. It was difficult to explore why most of these women were prone for this double jeopardy in this region but we were at least able to make them aware of the feasibility of combined surgery of genital and rectal prolapse concurrently at the same sitting in order to save their time, by two approaches preferably via vaginal route. What is more appealing to understand is the simplicity in the treatment of genital prolapse in this joint ventures that has uniformly remained the same comprising mainly of pelvic floor repair with vaginal hysterectomy coupled by few additional procedures performed simultaneously when they are specially required like, sacral colpopexy, sacrospinous suspension, rectopubic urethropexy, and abdominal fixation of the vagina to the uterosacral ligaments. While the surgery for rectal prolapse varied both in techniques and approaches either via perineum or abdominally. The most common way of dealing them were anterior resection performed after full rectal mobilization to the levator ani muscles with reanastomosis carried out to peritonealized distal rectum (39 hand-sewn and two stapled) followed by sigmoid resection with rectopexy (31), rectopexy with or without sigmoid resection (12), Altemeier procedure of transperineal rectosigmoidectomy (10), Ripstein procedure (3), Delorme operation (1)[documented to have zero mortality and morbidity rates but with relapse rate of 8 -11%] and laparoscopic rectopexy (1).[2-7]

Not only the surgical approach deferred in rectal prolapse repair but also the route of operation differed, abdominal, transperineal or also the method for an example laparoscopic approach at the same sitting of vaginal route hysterectomy.[7] In our hospital, rectopexy, Theirch's and Delormes' operation are adapted procedures for the repair of rectal prolapse and are preferably performed at the same sitting but not always. We have made requests for rectal prolapse repair as an out patient basis, a day or two before the vaginal hysterectomy in some of our women to minimize the operative time. We have also asked the favor of Surgeons for the repair of rectal prolapse few days or weeks after vaginal hysterectomy. One such unforgettable case that particularly comes to my memory is a case I attended many years ago when our ward sister frantically reported that, she discovered huge mass coming out of vagina in one of the woman operated by me few days ago for uterovaginal prolapse and wondered if it had been a vault prolapse. This was indeed a huge rectal prolapse, which had gone unrecognized and I cannot understand how. Quite on the contrary there have been reports of 4 women being referred for repair of vaginal prolapse after surgical correction of the rectal prolapse when concomitant genital and rectal prolapse had their diagnosis already.[3]

Conclusion

Women living with debilitating condition in the community with the dual existence of prolapses, that is emergence of rectal prolapse over the preexisting genital prolapse; an additional misery; must be made to realize their quality of life could be improved by availing the surgical corrections of these two prolapses occurring concurrently, simultaneously at the same sitting.

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