Spontaneous rupture of rectum with prolapse of small gut through the anus - a case report

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ABSTRACT
A 72-year-old lady presented with prolapsed loops of small bowel through the anus without any history of local trauma or instrumentation. The event followed excessive straining during defecation. Exploratory laparotomy revealed a deep pouch of Douglas, and rent on the anterior wall of the rectum, through which the bowel had prolapsed. The eviscerated small gut was reduced after proper cleansing and the rent on the rectal wall repaired without diverting colostomy. The patient had an uneventful recovery.

KEY WORDS
Rectum, rupture, evisceration

INTRODUCTION
Evisceration of the abdominal contents through the anus following spontaneous rupture of the rectum is a rare occurrence and 65 cases have been previously reported. The earliest reported case was in 1827 by Benjamin Brodie. The patient was a middle-aged lady who developed spontaneous rupture of rectum with evisceration of small bowel while straining during an episode of vomiting. The dramatic presentation and the sight of loops of small bowel protruding out of the anus is disturbing not only for the patient but for the attending physician as well.

CASE REPORT
A 72-year-old lady presented with the history of something coming out spontaneously through the anus associated with mild lower abdominal pain. The incidence occurred suddenly while straining during defecation. It was not associated with any bleeding per rectum. The patient was multiparous and had six living issues. She was chronically constipated but gave no history of any local trauma or instrumentation. There was no history suggestive of rectal prolapse or any previous history of surgery or irradiation. The patient presented within two hours of the incidence and on examination the patient was found to be anxious but cooperative. She was pale, pulse rate was 110 per minute, and blood pressure was 102/72 mm of Hg. There was slight lower abdominal tenderness on the left. A loop of small intestine, approximately 1.5 meters in length, was found lying between the thighs, coming out through the anus (Figure 1). The eviscerated gut was congested but viable. There was no sign of any local external injury. Per rectal digital examination was not attempted to avoid inadvertent injury to the gut.

Figure 1: Prolapsed loops of small intestine through the anus.
Per vaginal examination revealed 1° degree uterine descent associated with enterocoele. Baseline biochemical parameters of blood were all within normal limits. After resuscitation and within an hour of her admission she was explored through infraumbilical midline incision in dorsal lithotomy position. The small gut was found to be prolapsing out through a transverse slit-like rent, approximately 3 cm in length, in the anterior rectal wall approximately 2 cm from the peritoneal reflection. The pouch of Douglas was found to be deep. Rectum adjacent to the rent appeared to be thinned out. No other pathology such as polyp, malignancy or diverticulae was found in the rectum or the adjacent sigmoid colon.

The eviscerated loops of small bowel were washed with plenty of warm saline solution and gradually reduced into the peritoneal cavity. The colon contained hard stool. The rent was repaired extramucosally, in one layer, with 2-0 silk. No protective colostomy was performed. The Peritoneal cavity, especially the pelvic cavity, was once again washed with plenty of normal saline and the abdomen closed with a pelvic drain. Broad-spectrum antibiotics started preoperatively were continued postoperatively.

She had an uneventful recovery. Examination during the postoperative period did not reveal any rectal prolapse. At the time of discharge she was advised to consult a gynaecologist for the management of her genitourinary prolapse and to report for defecogram and anal function tests to elucidate the possible reasons for the condition. However, unfortunately, the patient never turned up in the follow-up clinic.

DISCUSSION

The large bowel usually perforates as a complication of a preexisting pathology of the bowel like ulcer, diverticulosis, colitis or following accidental or iatrogenic penetrating injuries. Rectal and distal colonic perforation may occur in association with malignancy, adhesions, irradiation, and perforating hematoma. Blunt trauma of the abdomen which causes a sudden increase of intra-abdominal pressure may also cause colonic perforation. Very rarely it may rupture spontaneously and intra-abdominal viscera may prolapse out through the anus. Though termed “spontaneous”, there are usually some precipitating factors like excessive straining during defecation, urination, vomiting or while lifting heavy weights. However, there are instances where no history of any form of strain is available; indeed it has also been reported to have occurred during sleep.

Chronic strain causes progressive deepening of the rectovesical or rectouterine pouch. Unsupported by muscle the rectal wall becomes thin and weak. Contraction of abdominal musculature during straining increases the intra-colonic pressure and spontaneous rupture occurs through this thinned out area, generally at the antimesenteric border where the blood supply is poorest. Straining in patients with chronic constipation with loaded colon increases the intra-colonic pressure further.

Perforation generally involves the distal large bowel and the rectum. As in this reported case, it is usually associated with evisceration of the small bowel. Omental extrusion has also been reported. Ellul et al reviewed the published literature and found that 76% of cases were associated with rectal prolapse. It can occur in all age groups, the youngest patient reported was six years old and the oldest being 96 years. There is no uniform sex preponderance in the reported cases.

The patient requires surgical intervention at the earliest opportunity under broad-spectrum systemic antibiotic coverage. The prolapsed bowel is replaced within the abdomen after thorough cleansing or resected if not viable. The ruptured large gut is repaired directly if the margins are healthy, avoiding colostomy. If the patient presents late, the margins of the tear are ragged and unhealthy or when there is peritoneal contamination, a protective colostomy is preferable. Exteriorization of the ruptured sigmoid colon is another alternative.

After recovery from the emergency surgical intervention these patients need to be further investigated to detect the exact aetiology of the condition. Cause-specific management will prevent recurrences or other complications associated with the primary disorder.

REFERENCES

Angiomyoma of soft palate - A case report

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ABSTRACT
Angiomyomas are benign neoplasm thought to originate from vascular smooth muscle. They have a propensity to
arise from the GIT and female genital tract (uterus) and subcutaneous tissue. The oral cavity is uncommon site for
angiomyoma. Here is an interesting case report of a rare palatal angiomyoma. A brief review of the literature and
histological variations have also been described.

KEY WORDS
Angiomyoma, soft palate

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CASE REPORT
A 35-year-old male presented to the ENT OPD with a
swelling of his soft palate, which was gradually
increasing in size for the past one year. It was not
associated with pain, bleeding, dysphagia or
odynophagia. There were no dental complaints and
there were no symptoms suggestive of any local
infection. On examination there was an intra-oral mass
averaging 2´3 cm, arising from the right soft palate
extending over to the hard palate with an intact
mucosal lining. It was firm on palpation and was non-
pulsatile. A FNAC of the swelling was performed intra-
orally, which yielded only blood. A contrast enhanced
CT scan (Figures 1) revealed an enhancing soft tissue
mass arising from the right soft palate, without bony
erosion. A provisional diagnosis of hemangioma was
made. The patient was taken up for excisional biopsy
of the intra-oral mass under general anaesthesia via
transoral approach. A histopathological analysis
(Figures 2) of the specimen revealed an angiomyoma.

DISCUSSION
A total of 139 cases of leiomyomas of the oral cavity
and pharynx have been reported till date (Hatch, Davis
et al, 2001), out of which only 19 have been palatal
angiomyomas (Svane, Smith, Cosentino, 1986).2
Angiomyomas are leiomyomas of vascular smooth
muscle origin.3,4 Benign smooth muscle neoplasm have
been classified into5
• leiomyoma (solid leiomyoma)
• angiomyoma (vascular leiomyoma)
• epitheloid leiomyoma (leiomyoblastoma)

Myxoid angiomyoma is a rare variant of angiomyoma
(Holder, Dellinger, 2001).6 A review of the literature
showed that the mean age of presentation of oral