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Rectal prolapse Due to anal Sodomy!!!!!!

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ABSTRACT *Rectal prolapse is a full thickness protrusion of the rectum through anal sphincters.starting appoximatly 3 inches above the dentate line and extending beyond the anal Verge. Common in older people but in young rectal prolaps is rare.Any condition which leads to sphincter laxity,weakness of the pelvic floor and perineal muscle tear leads to rectal prolapse .This paper discusses a case of partial rectal prolaps due to anal sodomy (one of the important risk factor for rectal prolaps) 18 year old female came to opd with partial rectal prolaps,on history she was practisingano receptive intercourse from past 5 years, she developed symptoms gradually ,each time she managed conservatively , Due to repeated anal sodomy,it leads to laxity of anal sphincter, tear to puborectalis sling ,and laxity of pelvic diaphragm Which can be corrected surgically*

Introduction: child abuse is a condition, which is not reported as frequently in society .anal sodomy is one of the abuse . which can leads to Anal Fissures, STD,HIV, Haemorrhoids and Finnaly Rectal Prolapse

We report a case of 18 year female who presented with intermittent episodes of a partial rectal prolapse ,on history she is practising anal intercourse since 5 years, twice per day .No medical and surgical co morbidity noted. she developed symptoms of mucous discharge ,chronic moisture of perineal area, mass per rectum during defecation ,faecal incontinence and prolapse of rectum in squatting position. Physical examination revealed grade 2 rectal prolapsed ,Genera and systemic examination was normal

Digital rectal examination revealed laxity of sphincter , anal fissure present, mucosa of rectum is thickened, with ulcerations

In squatting position it was grade 2 rectal prolaps

fig (1) grade 2 rectal prolaps

Routine investigations done, alone with anal manometry and MRI of anal canal.

Anal manometry report.....anal sphincter tone is decreased while defecating ,and straining so rectum is prolapsed from anal verge

MRI of anal canal ...gives puborectalis tear

She underwent wells procedure (abdominal rectoplexy) were posterior placement of the mesh on the rectum and rectum is fixed to sacral promontory after full mobilisation anteriorly and laterally , the procedure was performed successfully ,her post operative course was unevenfull

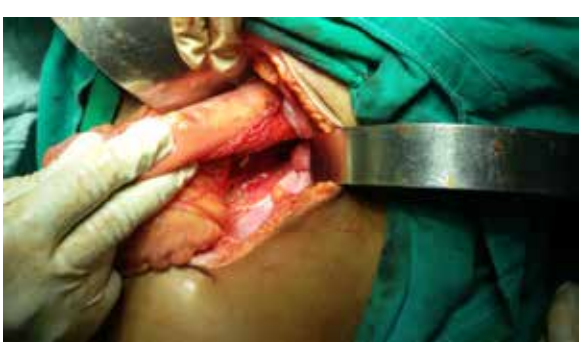

fig (2)abdominal approach ant rectal resection with rectoplexy

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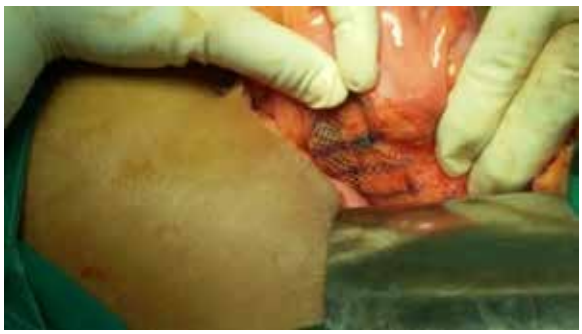
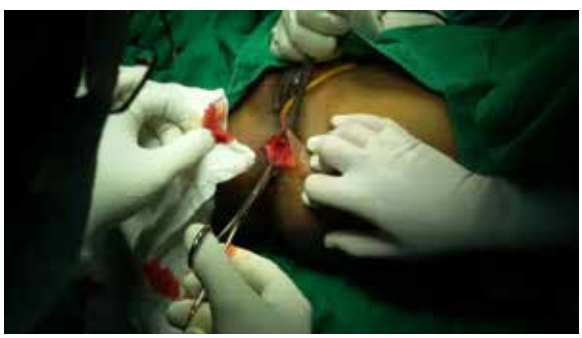
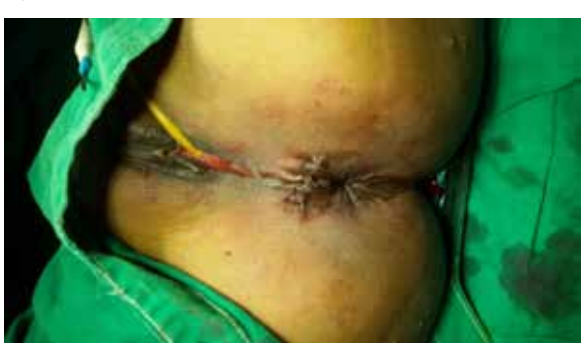


fig(3) showing mesh placement (posteriorly and laterally to rectum)



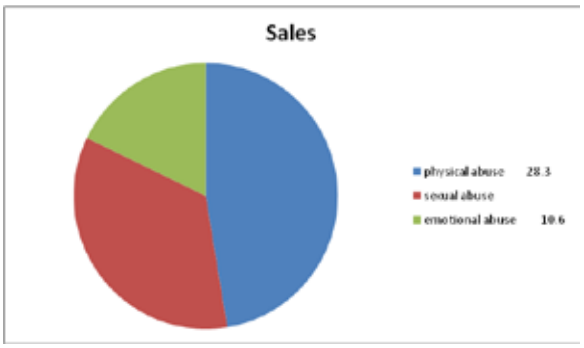
fig(4)incision for pubo rectalis repair (above the anal canal and below the vaginal orifice)

fig (5)a puborectalis repair



fig(5)b skin close

DISCUSSION 8% of males, and 6% of females reported having anal sex at least once a month . Of these, most engage in this activity one to five times per month, Younger respondents and those who were not married were more likely to report anal intercourse. ANAL INTERCOURSE practiced by up to 30% of heterosexuals .



CHILD ABUSE CATEGORY AND PREVALANCE(%)

LEAST PERCENTAGE OF CASES ARE REPORTED AND TREATED

People experience pleasure from anal sex due to stimulating anal nerve ending ,stimulating prostrate,pudendal nerve,internal and external anal sphincter muscles which control closure and opening of anal canal are sensitive membarane made up of nerve ending ,facilitate pressure

During repeated anal rectal intercourse ,anal canal become lax due to dilatation of anus there will be laxity of anal sphincters, leads to deep cul de sac which may herniated from posterior rectal fascia, pubo rectalis sling tear, levatour anis muscle laxicity damage to pudendal nerve .all contribute to rectal prolaps

Pelvic Floor Dysfunction

Abnormalities of the pelvic floor can lead to fecal incontinence. There will be decreased perception of rectal sensation, anal canal pressures, squeeze pressure of the anal canal, impaired anal sensation,rectal prolapse, rectocele and generalized weakness and sagging of the pelvic floor.

Anatomically, rectal prolapse is caused by weakening of the ligaments and muscles that hold the rectum in place. In most people, the anal sphincter is weak.

Advanced age	Long term constipation
Long term straining during defeaction	Long term diarrhea
Pregnancy and childbirth	Previous anal surgery
Cystic fibrosis	copd
Sphincter paralysis	

Reviews of the condition have pointed out several possible etiologies including

Defect of the pelvic floor	Redundant rectosigmoid colon
Deep Douglas pouch	A sliding hernia
Circumferential intussusception that develop in the anorectum	Anal sex

Patients with rectal prolapse often complain of symptoms

Prolapsed anal tissue or mass,	Anal mucoid secretions
Fecal incontinence	Loss of the urge to defecate
Bleeding from the protruding tissue	

The definitive treatment of rectal prolapse is surgical. Surgical treatment of rectal prolapse can involve a variety of methods, including

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Resection of redundant colonic or rectal walls	Repair of the pelvic defect
Fixation of the rectal wall to presacral fascia (rectopexy	

The different surgical approaches are described below.

1 The transabdominal procedures,
2 posterior rectopexy offer better functional results. For younger patients and older patients
3 transabdominal procedures are preferred. Therefore, resection of the sigmoid with rectopexy, or anterior and posterior rectopexy,
4 Transperineal procedures,
5 Delorme's procedure
6 perianal rectosigmoid resection. Perineal rectosigmoidectomy (Altemeier repair) is another safe and effective approach for elderly patients who have significant comorbidities.
7 The Thiersch procedure involves placing subcutaneous, perianal encircling sutures. It creates a temporary mechanical barrier to keep the prolapsing rectum reduced inside the anus,
8 Laparoscopic surgery offers better option due to its minimally invasive nature. .

Current laparoscopic surgical techniques include

1 suture rectopexy,
2 stapled rectopexy,
3 posterior mesh rectopexy with artificial materials

resection of the sigmoid colon with colorectal anastomosis with or without rectopexy. From our review of the literature, laparoscopic repair of rectal prolapse was found to be associated with better outcome. Carpelan-Holmstrom et al presented their experience of the management of 75 patients with rectal prolapse, in which 65 patients were treated laparoscopically, with a 6% conversion rate. They reported success rates of 84% and 92% for rectopexy and resection rectopexy, respectively, with no mortality and only minor morbidity, and considerable improvement of fecal continence

Conclusion

Surgery remains the definite treatment for complete rectal prolapse. Transabdominal procedures seem to be associated with better outcomes than transperineal repairs. Although the cases presented herein were managed with an open surgical approach, laparoscopic treatment of complete rectal prolapse can be successfully performed by trained laparoscopic surgeons. the advantages of shorter hospital stay and decreased pain.

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