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GIANT RECTAL PROLAPSE UNMASKING ANORECTOSIGMOID TUBERCULOSIS: A RARE SURGICAL CHALLENGE

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ABSTRACT

Giant rectal prolapse, commonly defined as prolapse exceeding 10 cm in length precipitated by Anorectosigmoid tuberculosis which is an uncommon form of gastrointestinal tuberculosis presenting with unique diagnostic and therapeutic challenges. We report a case of a 45-year-old male who presented with complaints of Loose stools, bleeding P/R associated with mucous discharge for 10 days, and H/o significant weight loss With no known comorbidities in Past. Clinical examination revealed acute gangrenous giant rectal prolapse necessitating surgical intervention. Early recognition and timely surgical/Anti Tubercular therapy are essential to prevent complications.

INTRODUCTION

Rectal prolapse is defined as the full-thickness circumferential protrusion of rectal wall through the anal verge. It predominantly seen in elderly women but may occur in men and younger individuals under specific predisposing conditions. Giant rectal prolapse is an uncommon variant, typically defined as a prolapsed segment measuring 10 cm or more, and is associated with higher rates of complications like edema, ulceration, ischemia and Gangrene.

The pathophysiology involves weak pelvic floor musculature, redundant rectosigmoid colon, and chronic increases in intra-abdominal pressure. While chronic constipation is the most commonly implicated factor, acute severe diarrhea with repetitive straining is a less frequently reported but important precipitating cause.

Tuberculosis remains a major global health concern, particularly in developing countries. Gastrointestinal tuberculosis accounts for a small proportion of extrapulmonary tuberculosis cases, with the ileocecal region being the most commonly involved site. Tuberculous involvement of the anorectal region and sigmoid colon is rare. The clinical manifestations are often nonspecific and may mimic colorectal malignancy, inflammatory bowel disease, or other anorectal disorders.

Complete rectal prolapse as the presenting manifestation of anorectosigmoid tuberculosis is exceptionally uncommon. We present this case highlighting this unusual presentation and the importance of considering tuberculosis in the differential diagnosis.

Due to its rarity, there is no standardized management protocol for giant rectal prolapse, and treatment is tailored based on patient condition, reducibility, and associated complications.

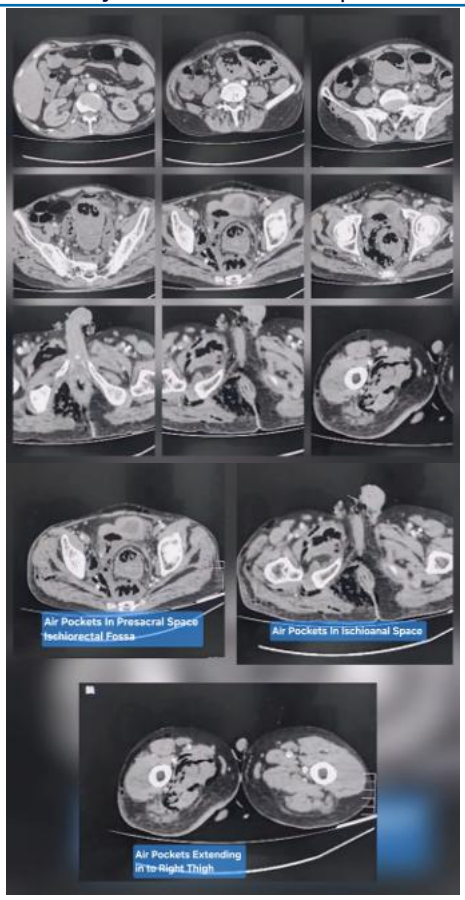
CASE PRESENTATION

A 45-year-old male, Mr. X, presented with history of loose stools 10–15 episodes per day for 15 days and mass descending per rectum for 4 days, progressively increased in size associated with pain and became irreducible. No abdomen pain, distension, fever. There was no prior history of rectal prolapse, chronic constipation, pelvic surgery, neurological disease, or trauma.

On examination, the patient was hemodynamically stable. Examination revealed a large circumferential full-thickness rectal prolapse, protruding about 25cms beyond the anal verge, consistent with a giant rectal prolapse. The prolapsed bowel was nonviable with evidence of gangrene and multiple perforation. Crepitus noted over perineum, right gluteal region and medial aspect of right upper thigh.Per abdomen Revealed mild Tenderness over left Iliac fossa ,no Guarding, no Rigidity,no distension.

Laboratory investigations were within normal limits. Based on clinical findings, a diagnosis of Acute Complicated giant rectal prolapse precipitated by severe diarrhea was made.

Imaging studies revealed Suspicious telescoping of sigmoid colon into rectum and ill-defined hypodense area with multiple air pockets in presacral region Extending into bilateral ischiorectal region, right ischioanal fossa tracking along the subcutaneous and intermuscular plane of medial aspect of thigh, right gluteal region and scrotum.No evidence of intraperitoneal free air/fluid.



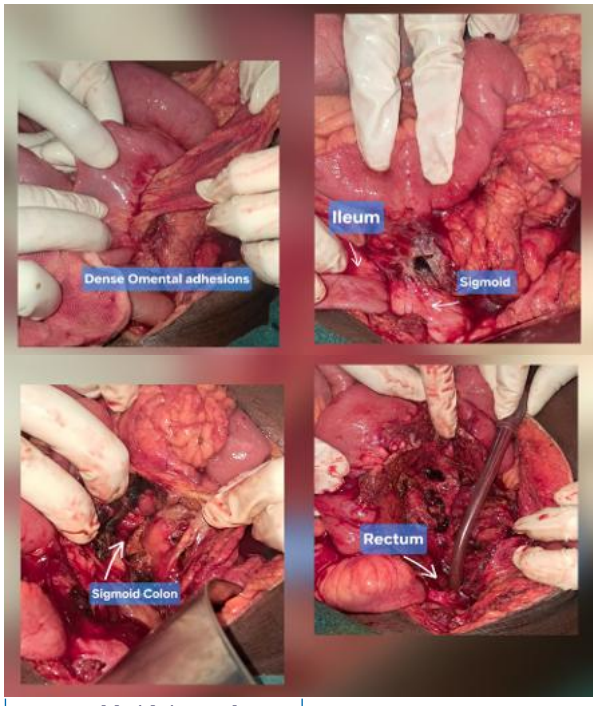
The patient was taken up for exploratory laparotomy.

Intraop findings

Prolapsed Gangrenous segment measuring 50cms was Removed per anum.

Dense adhesions between Sigmoid colon, rectum, omentum and ileum removed.

Revealing Gangrenous sigmoid colon with multiple Perforations and Pericolic Abscess Formations.



MANAGEMENT

Resection of Gangrenous segments of sigmoid colon and upper rectum with Diversion end colostomy was Done
Anti-tubercular therapy Was Intiated at the earliest
Other Options including Non-operative reduction and Perineal Procedures:
Altemeier procedure (Perineal rectosigmoidectomy)
Delorme procedure(Mucosal sleeve resection with muscle Plication)
Abdominal Procedures:
Rectopexy with or without mesh/with or without sigmoid resection
In giant, irreducible prolapse, especially with edema or impending ischemia, perineal rectosigmoidectomy remains the procedure of choice.

Pus Cultures revealed Smear Positive for Acid Fast Bacilli
HPE: Intense surface Ulceration with necroinflammation Consistent with Gangrene

DISCUSSION

Rectal prolapse is an extremely unusual presentation in gastrointestinal tuberculosis.Prompt intervention is essential to avoid irreversible bowel injury with Antitubercular Therapy is life saving. This case underscores the need for clinicians to maintain awareness of tuberculosis as a potential cause of atypical anorectal presentations, especially in endemic regions.

CONCLUSION

Giant rectal prolapse is a rare but an important surgical condition. Acute severe diarrhea with repeated straining can act as a precipitating factor even in younger patients. Early diagnosis and appropriate surgical management are crucial to prevent complications and achieve optimal outcomes. Due to limited data, further case reporting and studies are needed to establish standardized management guidelines.

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