Uterine and Rectal Prolapse, case report in simultaneous surgical management at the Hospital Nacional de Itauguá. 2018-2022

Prolapso Uterino y Rectal, reporte de casos en el manejo quirúrgico en simultaneo en el Hospital Nacional de Itauguá. 2018-2022

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ABSTRACT

Uterine prolapse is a common pathology in the female population as longevity increases. If we take into account the concomitant rectal prolapse that these patients may have, we see a not very high frequency, although both are part of the disorders of the pelvic floor, combined surgical treatment may be a valid option to improve the quality of life of these patients. We present the results of 3 patients who underwent transvaginal hysterectomy and Delorme operation in a single procedure with satisfactory results.

Key words: Vaginal prolapse, Rectal prolapse, Delorme Operation

RESUMEN

El prolapso uterino es una patología frecuente en la población femenina a medida que aumenta la longevidad, si tomamos en cuenta el prolapso rectal concomitante que pueden tener estas pacientes, vemos una frecuencia no muy alta, si bien ambos forman parte de los trastornos del piso pélvico, el tratamiento quirúrgico combinado puede ser una opción válida para mejorar la calidad de vida de estas pacientes. Presentamos los resultados de 3 pacientes sometidas a histerectomía transvaginal y operación de Delorme en un solo tiempo con resultado satisfactorio.

Palabras claves: Prolapso vaginal, Prolapso rectal, Operación de Delorme

INTRODUCTION

Pelvic organ prolapse (POP) is a complex disorder resulting from abnormal descent of the pelvic organs from its insertion origin on the pelvis. The pelvic structures that can prolapse include the bladder and anterior vagina (cystocele), posterior vagina (rectocele), uterus (uterus-vaginal prolapse), vagina in case of patients without uterus (vaginal vault prolapse), perineum (perineocele) and rectum (rectum prolapse). Depending on the presented symptoms and the organ involved, the prolapse is treated by a multidisciplinary team which includes a urologist, a urogynecologist or colorectal surgeon. Rectal prolapse may present itself in a variety of forms and is associated with a variety of symptoms that include pain, incomplete evacuation, blood and/or mucous rectal secretion, fecal incontinence or constipation. Complete external rectal prolapse is characterized by a circumferential and thick total protrusion of the rectum through the anus, which can be intermittent or imprisoned and poses strangulation risk. [1,2]

The Delrome technique for the complete rectal prolapse's treatment was first described by the French military surgeon Edmond Delorme in 1900. It's a perineal-way procedure which consist of the plication rectum's muscle layer with resection of the mucous layer. It has a recurrence rate of 5 to 22%, being higher for abdominal procedures (0-10%). [2]

Uterus or vaginal wall prolapse is a common condition, of which up to 11% of women require surgery during their life. The prolapse generally occurs due to a damage of the uterus or vagina's support structures. The weakening of these supports can occur during labor or because of chronic pushing such as constipation, chronic cough, obesity or as part of the aging process, other related risk factors are pelvic floor trauma, genetical factors, race, spina bifida. [3,4]

The rectal prolapse's presentation with uterus prolapses is associated to 50% cases. The treatment is surgical in both cases, hence resolution at the same time is a valid option with good results. [5]

Mortality and morbidity rates are zero is this surgery is performed and the recurrence rate is from 8 to 11% for rectal prolapse. [6]

A perianal handling tends to be favored for a rectal prolapse, especially in patients with comorbidities, given that these procedures are less invasive, typically cause less postoperatory pain and are associated with reduced in-patient stays. [7]

CLINICAL CASE'S PRESENTATION

We present 3 female patients of 60, 58 and 74 years old, who

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report to gynecology-obstetrics emergency services due to a tumor on the vaginal and rectal regions, one of them of 1 day of evolution, one of 3 days of evolution and one of 5 days of evolution, all of them with irreducible vaginal and rectal prolapsing without signs of necrosis. One of the patients with colpocystocele. Regarding base pathologies, all of them were hypertensive with regular treatment, one of them with chronic renal failure, dialyzed 3 times per week, one of them with a urinary tract infection. As obstetric history, they had 7, 5 and 8 vaginal births respectively. Between auxiliary methods only one patient had a transvaginal and abdominal echography that reported vesical and uterine prolapse. Only one of the patients had a colonoscopy, in which non-complicated colonic diverticulosis was discovered.

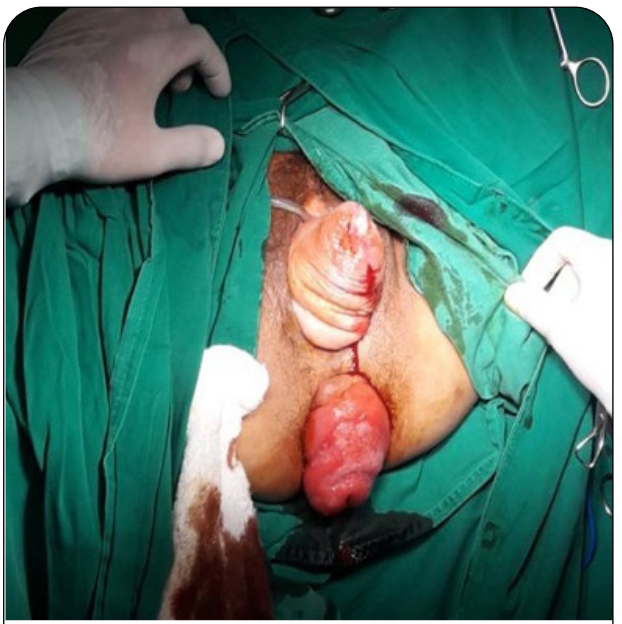

Figure 1. Patient with uterine and rectal prolapse.

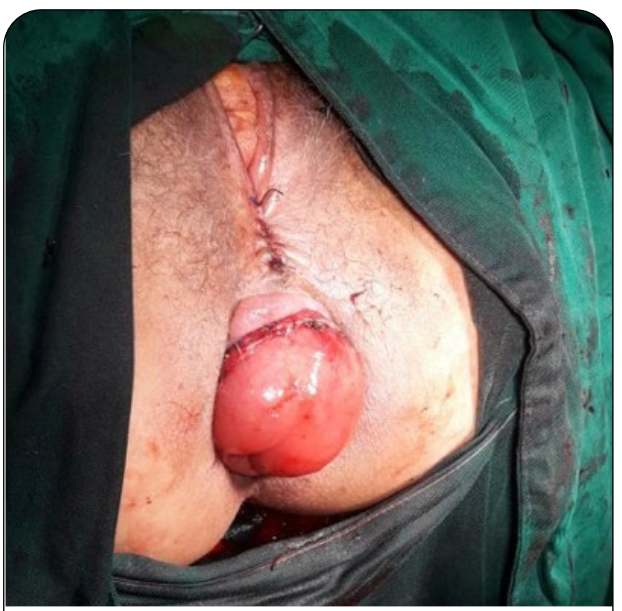

Figure 2. Uterine prolapse resolution with a modified Heany technique. After the vaginal hysterectomy, reparation of the rectal prolapse will take place.

In all patients, one-time surgical treatment was performed, a modified Noble Sproat Heaney technique was used for the uterine prolapse handling, which consisted of a vaginal hysterectomy with vaginal dome solidification on each side of the parametria's pedicle (uterosacral, cardinal and pubovesicocervical) and the deep pedicle (round ligament and annexal pedicle), afterwards we completed the anterior and posterior raffia with the vesicovaginal fascia's plication (Halban) and rectovaginal respectively; for the rectal prolapse's handling a mucosectomy plus plication of the rectum's muscle layer was performed (Delorme's Operation).

As postoperatory complication, a patient presented acute renal failure and urinary tract infection, the patient with chronic renal failure had an exacerbation of their renal failure which required handling in the intensive care unit, a patient didn't present any complications and was discharged after 7 days, the patients who were admitted into the intensive care unit were transferred to the common hall and then discharged after 24 and 25 days respectively. There was no mortality in any of the reported cases.

DISCUSSION

Several studies have suggested that a multidisciplinary focus of pelvic organ prolapse can improve the results of surgery and patient's symptoms. [3]

The handling and surgical technique choice for complete prolapse is founded in, fundamentally the characteristics of the patient, the size of the prolapse, the concomitant pelvic disorders and accompanying functional symptoms and intestinal habits. The surgery's goal is to correct the anatomical defect, alleviate the accompanying intestinal disfunction if possible and avoid later functional sequels. [8]

Mortality and morbidity rates are zero if this surgery is performed and the recurrence rate is only of 8 to 11% for rectal prolapse. We recommend indicating a mixed treatment of both prolapses if possible. Even though abdominal handling appears to be better than perianal handling regarding the prolapse's anatomical control and perhaps even functional, perianal handling has its advantages, especially in older patients and with multiple comorbidities, yielding proper anatomical and functional results. [8,9]

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