SPONTANEOUS TRANSANAL EVISCERATION OF SMALL INTESTINE: A CASE REPORT

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ABSTRACT: Transanal evisceration is an unusual phenomenon with less than 70 adult cases reported in the literature. It is predominantly seen in elderly and usually produced spontaneously. In the following case we describe a case of adult transanal evisceration. Introduction Transanal evisceration is an unusual phenomenon which is seen predominantly in elderly. It was first described by Brodie in 1827 but fewer than 70 adult cases reported in the literature since then.

Keywords: Transanal Evisceration, Rectosigmoid Region, Hartman Procedure.

CASE
A 55 year old male patient was brought to the surgical casualty found unconscious in the latrine. He is not a known patient with medical comorbidities. On examination he was dehydrated with a pulse rate, blood pressure, and respiratory rates were 102 beats per minute, 90/54mmHg, and 18 per minute, respectively. Abdomen was soft but edematous several loops of small intestine found hanging from the anus (Figure 1, 2). His white cell count was 16,000/ml

Figure 1
After resuscitation an emergency laparatomy was performed and found a craniocaudal anterior rectosigmoid tear with small bowel and sigmoid colon prolapsing through the defect. Small intestinal loops replaced and a Hartman procedure was performed. Patient was admitted to intensive care unit and succumbed on post operative 46th day due to lower respiratory tract infection.

DISCUSSION
Rectosigmoid perforation with small bowel perforation is an extraordinary occurrence. In adults it usually spontaneous in nature but blunt trauma to lower abdomen has been reported in few cases (2). About 70% of cases have found to be associated with chronic rectal prolapsed(3). The exact mechanism is not clear but it is postulated that the anterior rectal wall weaken due to chronic rectal prolapsed. Small bowel occupies the resultant deepened rectovesical pouch. In a precipitant event such as rise in intra-abdominal pressure in valsalva (coughing, defecation, straining) the weakened wall gives away. Other possible mechanisms of these injuries include repeated digitations for bowel evacuation, accidental penetrating rectal trauma and recreational activities. In our case the mechanism was not clear.
In children the mechanism is usually the suction injuries caused by swimming pool drains (4). When occluded the drain crates a powerful vacuum to pull out bowel transanally and rarely transperineally. Only recently non suction related evisceration reported in children associated accidental and self-inflicted rectal trauma (5).
Surgery is always necessary for the reduction of small intestine and to address the rectosigmoid laceration. Although several cases described primary repair of rectosigmoid laceration, repair of unhealthy edematous laceration may prove difficult and deleterious. Hartman procedure is often the preferred procedure in these patients with defecation problems, malnutrition, comorbidities and especially in a contaminated field.
The outcome depends on many factors including the degree of contamination, viability of bowel and comorbid conditions. Our patient was septic at presentation but with surgery he improved but weaning from ventilation became difficult for he had poor respiratory reserve and he succumbed due to ventilator associated pneumonia.
The pathology represented by this case is uncommon. Early diagnosis, resuscitation and damage control surgery to prevent sepsis and extensive resection should be the goals for a better outcome.

REFERENCES