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Research Article

**STUDY TO KNOW THE SURGICAL OUTCOME OF
PATIENTS WITH COMPLETE RECTAL PROLAPSE**¹Dr. Zainab Bilal, ²Dr. Hafiza Tuba Tariq, ³Dr. Omer Farooq¹Punjab Medical College, Faisalabad, ^{2,3}Aziz Fatimah Medical and Dental College, Faisalabad.**Abstract:****Objective:** To evaluate the results of patients with complete rectal prolapse.**Study Design:** A Case series study.**Place and Duration:** In Allied Hospital Faisalabad this study was conducted for three year duration from January 2015 to January 2019.**Methods:** A total of 24 patients were examined. The study included complete rectal prolapse including men and women older than 12 years. All patients with low gastrointestinal symptoms, ie bleeding from the rectum, tenesmus, pain and anus are examined according to history and examination. We recommended abdominal rectopexy, anterior resection and abdominal suture to these patients. Patients were followed to record any complication and recurrence.**Results:** A total of 24 patients were included in our study. Eighteen (75%) were male and six female (25%). All patients (24) complained about something coming out from the anus and discomfort. The duration of symptoms in 3 patients was less than 2 years, in 15 subjects 3-5 years and in six patients more than 6 years. 21 patients underwent resection of Wells, 2 patients underwent resection and one patient underwent their suture. Materials used were ivolone sponge in 3 patients, merslene mesh (5 patients) and prolene mesh (13 patients). Postoperative complications were pelvic abscess, wound infection (2 patients) and constipation (4 patients). There was no postoperative sudden death.**Conclusion:** In conclusion, Wells' abdominal rectopexy is a technically feasible method, with zero recurrence rate, short hospital stay and improved continence in most of our patients.**Key words:** Complete rectal prolapse, prolene mesh, Wells abdominal rectopexy.**Corresponding author:****Dr. Zainab Bilal,**

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INTRODUCTION:

Broden and Snellman (1968) have shown that the main abnormalities in the prolapse use cineradiography as a stubborn perception of the rectum, which initially started on peritoneal reflection¹. The weakness of the pelvic floor, a commonly associated phenomenon, is probably secondary to prolonged periods of prolapse or tension over extended periods of time. Numerous operations have been described to treat complete rectal prolapse². The dissatisfaction with the long-term consequences of previous procedures led to the abandonment by most surgeons. Operations that are still in fashion, the rectum is fixed by fixing the sacrum or symphysis pubis³. Rectopexy was first described by Wells (1959). We want to report our full rectal prolapse experience in 24 patients.

MATERIALS AND METHODS:

This Case series study was held in Allied Hospital Faisalabad for three-year duration from January 2015 to January 2019.

A total of 24 patients were included. The study included complete rectal prolapse including men and women older than 12 years. Recurrent prolapse, chronic liver disease, renal failure and patients having colorectal pathology (ie colorectal cancer) with medical problems were excluded from the study. All

patients with low gastrointestinal symptoms, ie bleeding from the rectum, tenesmus, pain and anus are examined according to history and examination. These patients were accepted through our department or were referred from peripheral, first and second level centers. The diagnosis of complete rectal prolapse was made by rectal examination including PR and proctoscopy. The laboratory investigations were carried out at Allied Hospital Faisalabad. Preoperative preparation of the patient includes intestinal and mechanical preparation of oral and parenteral antibiotics. These patients underwent abdominal rectopexy, anterior resection and abdominal suture. After the operation, patients received intravenous antibiotics and analgesia for the first two days, followed by oral antibiotics and analgesia for the following five days. The evaluation was performed on the first two days (these days, the patient was in the postoperative period) and on the first follow-up visit (one week after discharge from the hospital). There, after the follow-up, it was done every two weeks to seek some complication or relapse.

RESULTS:

A total of 24 patients were included in our study. 18 (75%) men and 6 (25%) women were shown in Table 1.

Table 1: Gender distribution

Sex	n=	%age
Male	18	75
Female	06	25

As shown in Table 2, most of the patients (11) were between 21 and 30 years of age.

Table 2: Age distribution

Age group	n=	%age
12-20	04	16.6
21-30	11	45.9
31-40	05	20.8
41-50	02	08.3
51-60	01	04.2
>61	01	04.2

All patients (24) complained about something from the anus and discomfort and duration of symptoms is shown in Table 3.

Table 3: Duration of symptoms

Duration of symptoms	n=	%age
<2 years	03	12.5
2-4 years	15	62.5
>4 years	06	25.0

21 patients underwent rectopexy. As shown in Table 4, the remaining 2 patients underwent pre-resection and Theirsh stitch was applied to an elderly patient.

Table 4: Type of repair

Type of repair	n=	%age
Well's posterior rectopexy	21	87.5
Anterior resection	02	08.3
Thieresh stitch	01	04.2

The material types used for Rectopexy were ivolone sponge (3 patients), merslene mesh (5 patients) and prolene mesh (13 patients) as shown in Table 5.

Table 5: Material used

Material used	n=	%age
Ivolone sponge	03	14.3
Merslene mesh	05	23.7
Prolene mesh	13	62.0

Postoperative complications were Pelvic abscess (one patient), wound infection (2 patients) and constipation (4 patients) were shown 6th Table.

Table 6: Postoperative complications

Complications	n=	%age
Pelvic abscess	01	04.2
Wound infection	02	08.3
Constipation	04	16.7

DISCUSSION:

There is no optimal or standard procedure for the treatment of all rectal prolapse. A consensus that we achieved 10 years later was that the abdominal procedures were associated with a lower recurrence rate than the perineal shown in the study by Habr-Gama et al⁴. However, Madoff and Kim et al indicate that abdominal procedures are associated with greater morbidity and are preferred for younger patients with related conditions⁵. On the other hand, perineal procedures are associated with lower morbidity, but have a higher recurrence rate than abdominal procedures and should therefore be considered in older patients with multiple comorbidities⁶. The selective policy has probably improved its outcome, but it does not aim to select a particular type of operation, as Brown et al. For many surgeons, abdominal rectopexy is the preferred procedure for low morbidity and recurrence rates, as shown in our study. In our study, 25% of women and 75 %men, this could be explained by our male-dominated culture. Male dominance was tested by Scaglia et al. , Huber et al and Boutsis et al⁷. In our study, female patients were slightly older than their male counterparts; this was reported by Keighley et al. Anus excision mass, discomfort in the perineal region, bleeding in the rectum, etc. All patients in our series presented the main complaint that something had come out of the year. Patients with prolapse had an irregular disorder and therefore constipation was

also analyzed by Scaglia et al. Peroperative hemorrhage was observed in only 6.7% of patients; this was due to the placement of the sutures in the sacral anterior fascia and as a result of the lesion of the vessels⁸. Bleeding was achieved without any problems with manual pressure and packaging. Bleeding may occur due to injury to the iliac and gonadal vessels, but not in our series. Another observed complication was the difficulty in placement of the web, probably due to various anatomy, as observed by Vongsangnak et al⁹. Another problem in the first cases in our study was wound infection (6.7%)¹⁰⁻¹². Prophylaxis with intravenous antibiotics and the incidence of wounds were abundant before closure. The median hospital stay was 1 week in our study. 87.5% of the patients were discharged weekly¹³⁻¹⁵. Only 12.5% of the patients were discharged late (up to 17 days postoperatively) and the reason for late discharge was successful infection control of the treated wound and pelvic abscess. In our study, no incontinence and recurrence was observed in the mean follow-up period of three and a half years. What has been observed in his study by Brown et al.

CONCLUSION:

As a result, Wells abdominal rectopexy is a technically feasible method, which has a zero-recurrence rate, short hospital stay and improved continence in most of our patients. In our patients with mild constipation, a

significant increase in the degree of continence was successfully treated with a fiber-enriched diet and the use of intermittent bulk-forming agents.

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