SHATTERED RECTUM - A SIMPLE METHOD OF REPAIR

Pages with reference to book, From 108 To 111

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INTRODUCTION

Anorectal injury is rare. Usual cause is fall on a sharp object but with an increase in road traffic and lawlessness on the roads, we foresee more of this injury as a result of crushed pelvis.
In difficult circumstances, a staged-splint-age technique may be useful specially as, in our circumstances, blood is a very difficult commodity to get.

CASE REPORT

In May 1985, a 35 years old man from a village in Okara District, riding a donkey cart was hit by a heavy duty truck. Two days after the accident, he was admitted in state of shock, in South Surgical Unit of Mayo Hospital, Lahore.
He had a large lacerated wound in his perineum. The anus was shattered and on rectal examination a large cavity was entered in which the baloon of a foley's catheter, passed per urethra was felt (Figure 1).

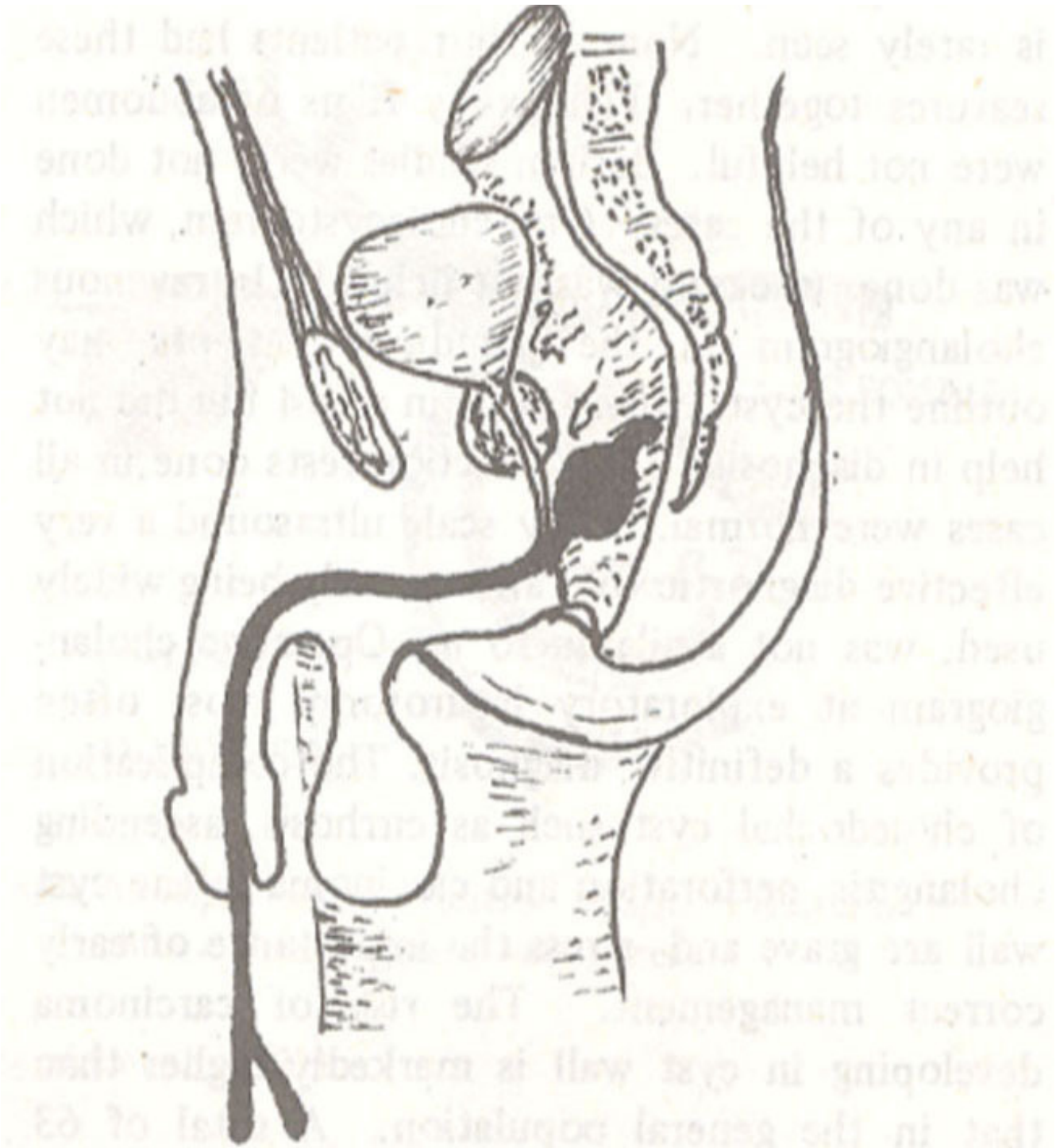

Figure 1. Foley's Catheter Felt in the shattered RECTUM.

The abdomen was soft, non tender and bowel sounds were audible. The bladder was palpable.

Figure 2. Foley's Catheter coming out of the shattered anal Canal & Rectum.

Pelvic tenderness was present and, on X-rays, both superior pubic rami were found to be fractured. The pubic symphysis was split open.
Following resuscitation and blood transfusion, railroad catheterization of the bladder was carried out and a sigmoid colostomy made.

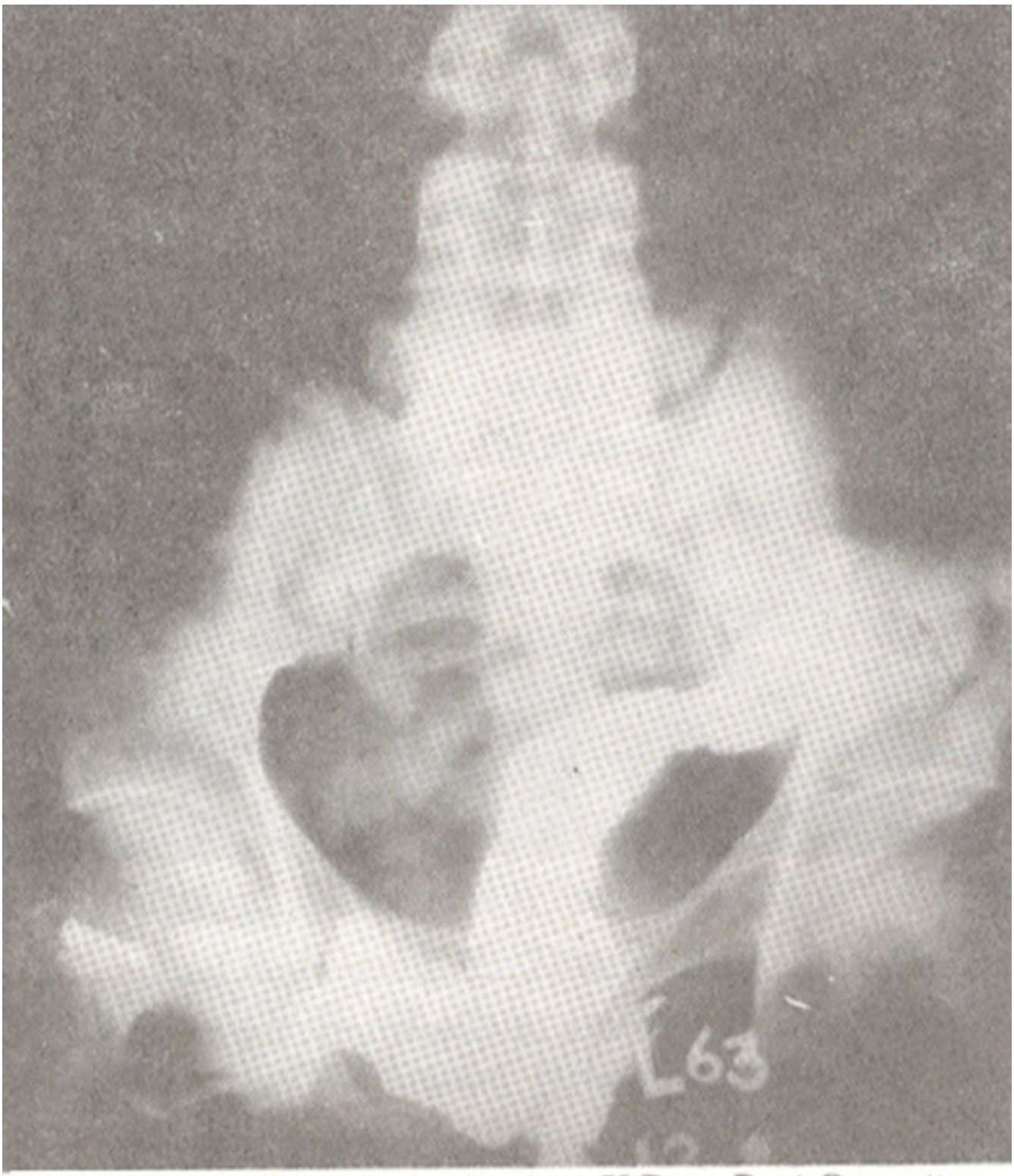

Figure 3. Per Colostomy Barium X-Ray. Post Operative.

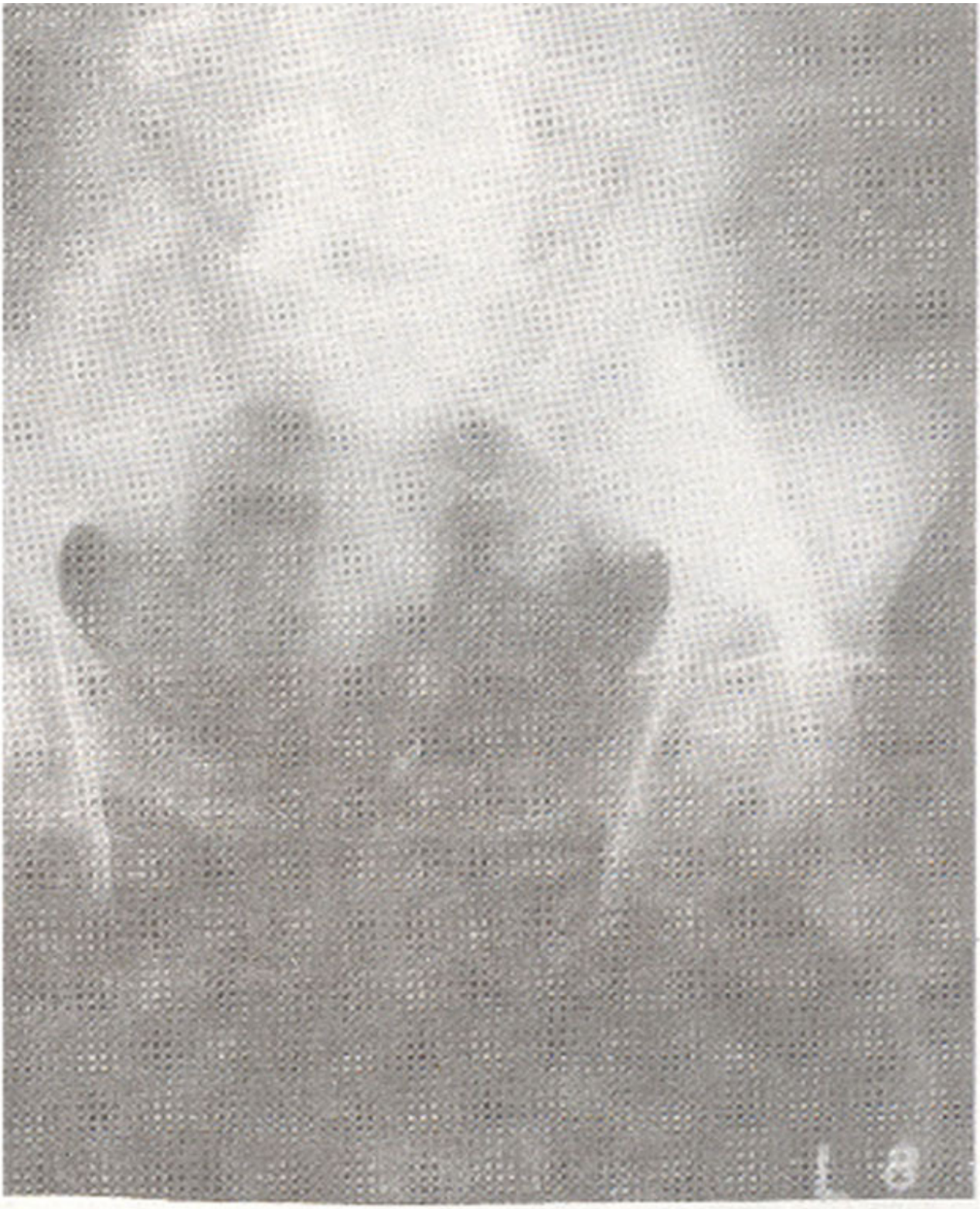

Figure 4. Rectal Tube Used as splint through the Colostomy.

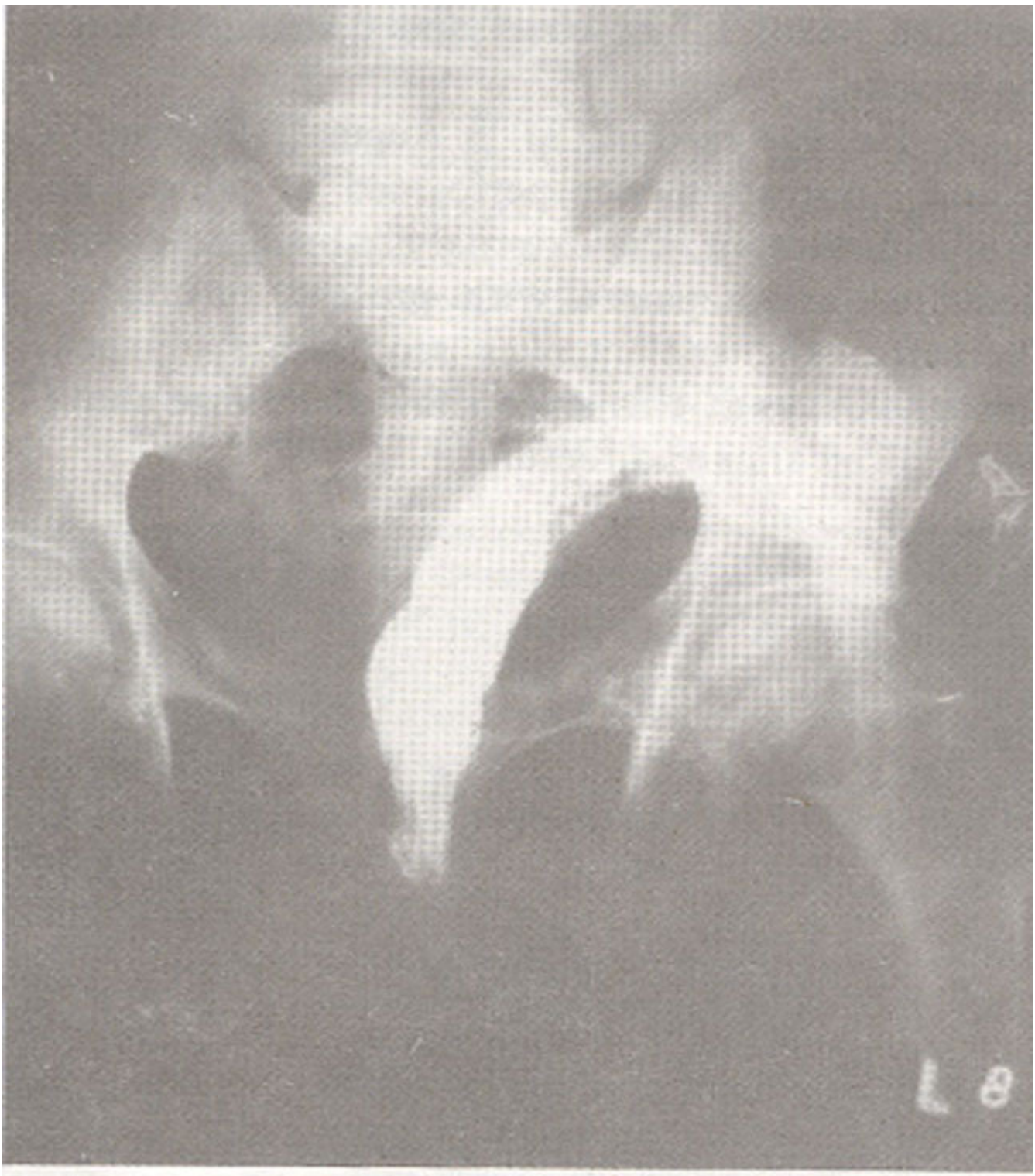

Figure 5. X-ray after the splint.

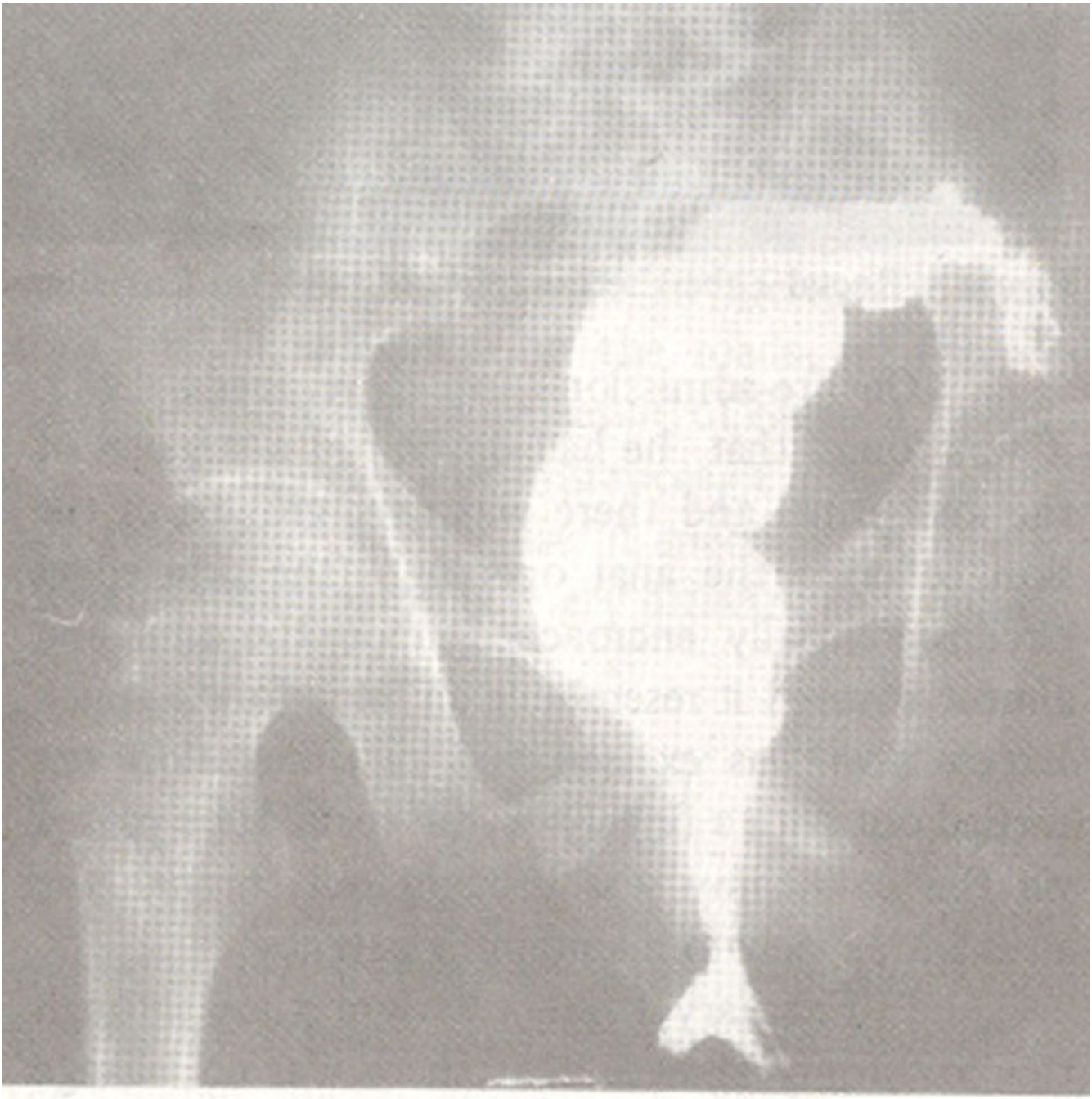

Figure 5 & 6. Barium X-ray after the Splint. Showing healing of Rectum & Anal Canal around the Splint.

Post-operatively, the patient recovered well his colostomy started functioning and the perineal wound, which was dressed twice a day, started to

At the end of a month, the patient was provided with a diet chart and discharged from the hospital. He was readmitted in August, 1985 and a second operation was performed at which, by careful dissection, the external anal sphincter was identified and repaired with prolene sutures[1,2] Thereafter the patient was sent, home to recuperate. X-rays at this stage showed leakage above the repaired anus and

rectum.
On re-admission in November, 1985, it was found that he had developed a stenosis of the anal canal and there was over growth of the skin covering the anal opening (the skin edges circumferentially encroached upon the anus and almost covered it resembling an imperfórate anus). Excess skin was excised and anal dilatation was carried out with a fmger. A 30F rectal tube passed via the colostomy was brought out through the anus with a view to maintaining patency.

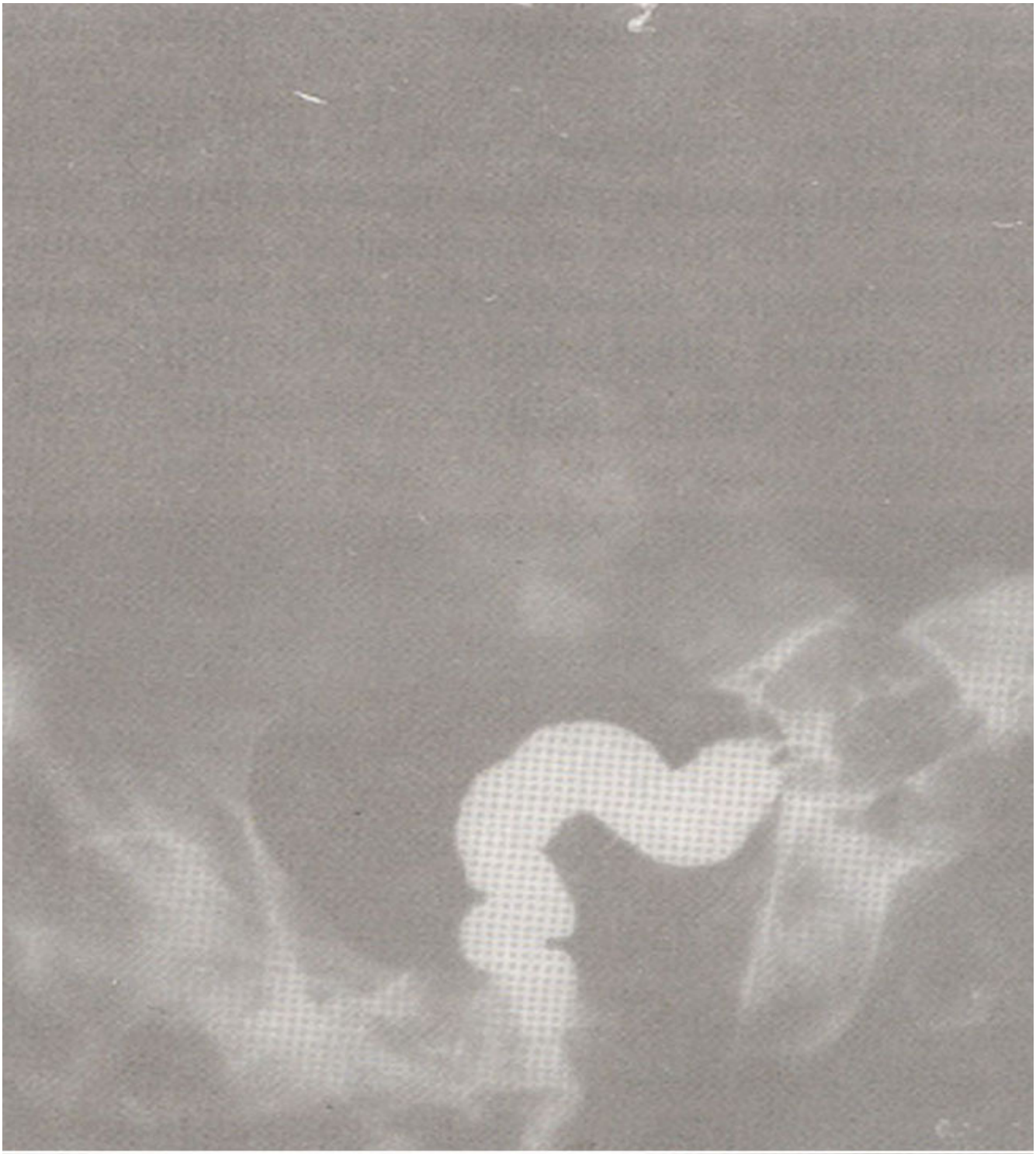

Figure 7. After the removal of the Splint. Complete healing of the Rectum & Anal Canal.

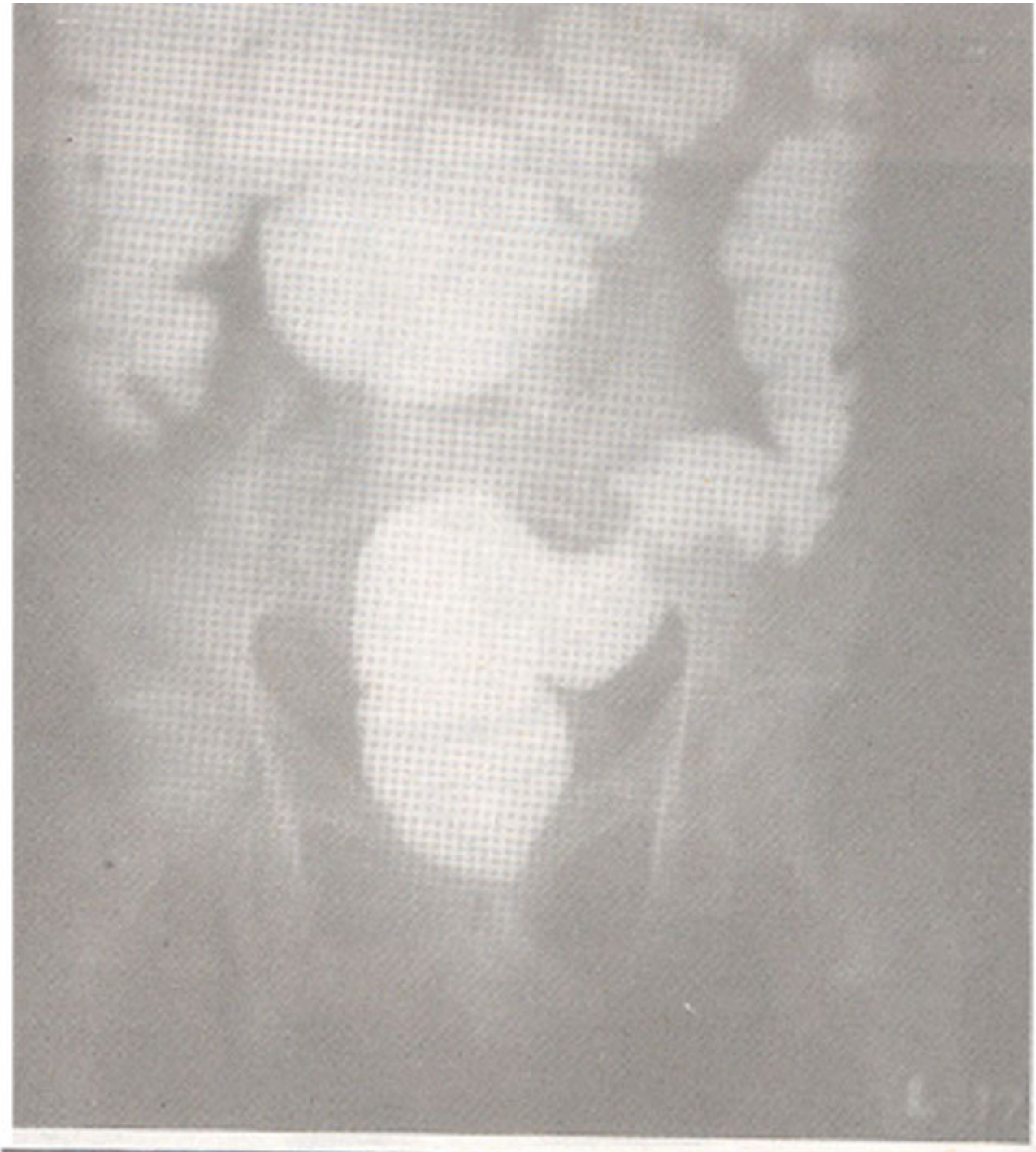

Figure 8. After the closure of Colostomy. Barium Enema showing Complete healing & Control of Anal Sphincter.

In February 1986, a barium study through the colostomy showed that there was no leakage through the rectal walls (See serial X-rays). Improvement in sphincter control was demonstrated at this stage by the ability to retain barium and grip a finger passed into the anal canal. The colostomy was closed

following which the patient started passing stools normally and had a good sphincter control
In order to prevent anal stenosis the patient had been instructed to regularly dilate himself manually with a London Hospital dilator.
The patient has since been followed on outpatient basis for six months during which he has had no complaints and has been advised to continue with anal dilatation.
In a fractured pelvis a combined abdominoperineal approach for rectal repair may be hazardous because of profuse blood loss. Blood is not easily available. Staged treatment of a shattered rectum by the method described is therefore a useful alternative. Failure of sphincteric repair is a hazard and permanent colostomy may be required.

DISCUSSION

Rectal injury is uncommon. The usual cause is a fall on a sharp object[3]. Jatrogenic causes include sigmoidoscopy and administration of enemata especially in inflammatory bowel disease. With an increase in road traffic accidents, crush injury of pelvis may be encountered more frequently as a cause of rectal trauma. Digital examination of the rectum is helpful in the diagnosis. It is said that any rectal wound left unstitched is likely to re-open after the closure of a defunctioning colostomy[3,4] In our patient the healing took place around a splint - This method is not very well documented.

REFERENCES

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4. Maingot, R. Abdominal operations. 6th ed. New York, Appleton Century-Crofts, 1974, vol. 2, p.1839.