AN INTEGRATIVE REVIEW ON ‘RECTAL PROLAPSE MANAGEMENT’.

Dwivedi Amarprakash,1* Pathrikar Anaya A.2

1. M.S.(Shalya Tantra), Ph.D., Professor, School of Ayurveda, D. Y. Patil Deemed to be University, Navi Mumbai, Maharashtra, India.  
2. M.D. (Kayachikitsa), Professor, AVPM’s Ayurved Mahavidyalaya, Sion, Mumbai, India.

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ABSTRACT
Rectal prolapse implies falling out of the rectum through the anus due to loosening of its normal attachment inside the body. It is categorized into partial prolapse (without muscular layer) and complete prolapse of rectum which affects mostly adults and women over 50 years of age. The established treatment includes conservative measures such as correction of constipation, sub mucosal injection and surgical procedures such as rectopexy etc. with varied prognosis. Rectal prolapsed can be co related with ‘Guda bransh’ described in Sushrut samhita. Further, Sushrut has advocated manipulation (reduction) of protruded part, local fomentation, lubrication with medicated Ghrita (clarified butter) and Ksharkarma adjuvant to internal medicines having Vata pacifying and rejuvenating property. The manuscript attempts to simplify rectal prolapse management and touches maximum aspect of this embarrassing condition. This article will certainly prove useful to proctologists and researchers, who wish to enrich their knowledge about integrated rectal prolapse management.

Keywords: Rectal prolapse, Rectopexy, Gudabransh, Mooshak tail, Changeri Ghrut, Ksharkarma.

1. MODERN PERSPECTIVE

1.1. INTRODUCTION
The term- ‘Prolapse of rectum’ implies a circumferential descent of the bowel through the anus. If this involves only mucous membrane, the condition is said to be one of incomplete or mucosal prolapse, if the entire thickness of rectal wall is extruded the term complete prolapsed or procidentia is used. Mucosal prolapse being commonest in young children, whilst complete prolapse found chiefly in elderly patient. In children, the incidence is high in the first two years of life. Boys are affected slightly more frequently than girls. In elderly, complete prolapsed cases, it is chiefly found in 5th decade of life and more common in females.1

1.1.1. Incidence
Overall, rectal prolapse affects relatively few people (2.5 cases/100,000 people). This condition affects mostly adults, and women over 50 years of age are six times as likely as men to develop rectal prolapse. Most women with rectal prolapse are in their 60’s, while the few men who develop prolapse are much younger, averaging 40 years of age or less. In these younger patients, there is higher rate of autism, developmental delay, and psychiatric problems requiring multiple medications. Although an operation is not always needed, the definitive treatment of rectal prolapse requires surgery.2

1.1.2. Etiology
The common etiological factor of rectal prolapse is as below:

- Decreased sacral curvature and decreased anal canal tone in infants
- Diarrhea, Cough, Mall nutrition- in children
- Reduced Ischio-rectal fossa fat, poorly developed pelvis
- Neurological cause

*Corresponding Author: Amarprakash Dwivedi. Email: amardwivedi@dypatil.edu
Fibrocystic disease of pancreas
- Common in multi-para Females- (due to repeated birth injuries to perineum damages perineal nerve supply)
- Weakening of supporting tissue and Levator ani muscle, Atony of the sphincter, increased intra-abdominal pressure, stricture urethra etc.

1.2. PARTIAL PROLAPSE
It is the commonest type of rectal prolapse. In this only mucosa and sub mucosa of the rectum descends (not more than 3.75 cm). Further, there is no descend of muscular layer in partial prolapsed of rectum.

1.2.1. Clinical Feature
- Partial prolapsed of rectum is pink in colour and mostly circumferential.
- Patient presented with History of Mass per Anum, while straining in squatting posture.

1.2.2. Treatment: In children / Infants
Mucosal prolapse in children is essentially a self-limiting disease, responding to non operative treatment such as correction of constipation (Liq. Paraffin etc.) and institution of proper habits of defecation. The child is taught to defecate promptly, no prolonged period of straining being allowed. Further, digital repositioning (Patient is trained for Manual reduction of mass), daily enema, and supporting the anus manually or by strapping can also be advocated.

1.2.3. Operative treatment
- Sub mucosal Injections- 1-2 ml. of 5% phenol in Almond oil is given at 3-4 places. This is a sclerosing agent which causes aseptic inflammation which leads to fibrosis of mucosa, preventing prolapsed.
- Temporary Thiersch Surgery- Insertion of subcutaneous stitch of chromic catgut round the anus is commonly practiced in children and infants. Further, rectopexy, where, retro - rectal space is entered, followed by suturing of rectum with sacrum can be done.
- Linear cauterization of the mucosa is also practiced with varied prognosis.

1.2.4. Treatment: In Adults
- Local treatment- Submucosal Injections
- Excision of Prolapsed mucosa (if prolapse is unilateral)
- Endo-luminal stapling mucosa (if circumferential)

1.3. COMPLETE PROLAPSE
Complete prolapsed of rectum is less common than partial prolapsed. It is also called Procidentia. The descend is always more than 3.75 mm (up to 10-15 cm) and contains all the layers of the Rectum (including muscular layers). It is due to weakened Levator Ani & Supporting Pelvic tissues and is also thought to be as an intussusception of Rectum. It drags peritoneum as pouch, containing small intestine. It is more common in Females (6:1) and is also associated with uterine descent/prolapsed.

1.3.1. Etiological factors
- Weak Anus, External sphincter and Pelvic muscle
- Lax, mobile Rectum
- Obliterated Ano Rectal angle
- Abnormally mobile Rectum with descent

1.3.2. Evaluation of rectal prolapsed
The patient may be asked to squeeze and relax their anal sphincter while the doctor has their finger in the patient’s anus. This digital examination is important and often reveals low anal sphincter tone. Further, Anal Manometry, Defecography / Sigmoidoscopy and Colocystodefecography are the advanced diagnostic investigations for confirmation of the condition.

1.3.3. Clinical Features
- Complete descent of the rectum is Red in colour and often Painful, as Mass per Anum.
- P/R examination reveals- Lax sphincter.
- Anteriorly, peritoneal sac comes down, as a pouch which may contain Small intestine.
- On digital pushing, it reduces with gurgling
- Fecal incontinence due to disruption of anal sphincter and prolapsed rectal mucosal dis-
1.3.4. Treatment

There are two general approaches to surgery for rectal prolapse – Abdominal operations and Perineal operations. Both approaches aim to stop the prolapse from occurring again and usually result in a significant improvement in quality of life. The choice of surgery type depends on both patient factors and procedural factors. Patient factors include the patient’s age, sex, bowel function, continence, prior operations, and severity of associated medical problems. Procedural factors include extent of prolapse, what effect the procedure might have on bowel function and incontinence, complication rates of the procedure, recurrence rates of the procedure and the individual surgeon’s experience.

1.3.5. Surgery

The commonly practiced surgical procedure for rectal prolapse is rectopexy. There are two approaches to surgery such as abdominal operations and perineal operations. Both approaches aim to stop the prolapse from occurring again and usually result in a significant improvement in quality of life. Further, some of the effective and commonly practiced operative procedures worldwide are described below:

1.3.6. Thiersch Operation

- Perineal approach- The main objective of this procedure is Circumferential Suture around the Anal Canal with steel wire/ Nylon to fix the prolapse. The procedure complications include Peri-anal Sepsis and Anal Stenosis
- Abdominal Approach- The principle of all Abdominal operations for Rectal prolapse is to Replace & Hold the Rectum in its Proper position.

1.3.7. Delorme’s Operation

This procedure is commonly known as Trans anal rectopexy. In this procedure, the rectal mucosa is removed circumferentially, from the prolapsed rectum over its length. The underlying muscle is then plicated with a series of sutures such that, when these are tied, the rectal muscle is concertinaed towards the anal canal. The anal canal mucosa is then anal sutured circumferentially to the rectal mucosa remaining at the tip of the prolapse. Thereafter, the prolapse is reduced and a ring of muscle is created above the anal canal, which prevents recurrence.

1.3.8. Ripstein’s operation

In this operation, the rectosigmoid junction is hitched up by a Teflon sling to the front of the sacrum just below the sacral promontory. The technique can be modified as sutured rectopexy and resection rectopexy.

1.4. COMPLICATIONS

In surgical practice, though the choice of surgery type depends on both patient factors (age, sex, bowel function, continence, prior operations, and severity of associated medical problems) and procedural factors (extent of prolapse, bowel function - continence status, complication risk and recurrence rates), the perineal approach is preferred as there is no risk of damage to pelvic autonomic nerves.

Further, the complication of rectal prolapsed surgery includes post operative sign and symptoms such as proctitis, ulceration, sense of obstruction, fecal impaction, sepsis, incontinence, and recurrence (6-7%) if wire/suture breaks or removed etc. The severe complications found are injury to hypogastric nerve leading to - impotency, bladder dysfunction, irreducibility, gangrene, rupture of prolapse and bleeding from sacral venous plexus etc.

2. AYURVEDIC PERSPECTIVE

2.1. Guda bramsh

Based on resembling clinical features, Guda bramsh is a condition which can be co related with Rectal Prolapse. Sushruta has explained Guda bramsh in 13th Chapter of Nidan sthan named Kshudraroga nidan adhyay. As per Sushrut samhita, a prolapse or falling out of the...
The protruded part should be fomented and lubricated with sneha (preferably with Goghrita). It should then be gently re introduced in the anus followed by Gofana bandh (T-bandaging) with leather belt (having an opening/ hole laying below anus for passage of flatus). Fomentation and oleation of the affected part should be done frequently with oils / Ghee medicated with drugs such as nirgundi, Bala, yashhtimadhu, panchvalkal etc. Similarly, Balya – Bruhaniya formulations (strengthening ligaments, sphincter and muscle tone) such as Kushmand Avaleh, Sarivadi vati, Shatavari, Krauncha paak and Vata pacifying drugs such as Nishoth, Suranpindi vati, Triphala can be prescribed.

Similarly, use of a very distinct formulation named Mooshak siddh tail, a medicated oil prepared by boiling milk, mahapanchmoola & flesh of mouse is also mentioned in Ayurvedic text for panabhyang (to be used internally and locally as pichu).

Another, effective regimen for Guda bramsh management is Changeri Ghrut, which is prescribed 10-20 Ml. twice a day with warm water or milk for 3 to 6 months.

2.5. Kshar application in Guda bramsh

Kshar karma i.e. local application of ‘Pratisaraneeya Kshar’ (alkaline-caustic paste) is very effective in Grade II / III non-bleeding internal haemorrhoids and early stages of Guda bramsh i.e. partial prolapsed of rectum. The Kshar paste is applied to the mucosa with the help of probe under the guidance of slit- proctoscope. After Kshar application the mucosa is washed with Dhanyaamla (sour gruel which neutralises the chemical reaction) and followed by local application of Yashtimadu Ghrita. Similarly, Kshar tail- matra basti (Enema) or pichu can also be prescribed with varied results. It is hypothesized that, Kshar karma causes protein coagulation and fibrosis of the tissues which hardens the prolapsed mucosa same as seen with sclerosing agents.

2.6. Dietary regimen

There are certain dietary regimens mentioned in early stage of Arsh chikitsa, which can be advocated in Guda bramsh such as:

- Gruel mixed with Ghrit or Milk, Shatavari mula kalka with milk, Apamarga mula cooked with rice, Butter milk, Jaggery with Haritaki
- Use of Suran (only for Dry piles) and Takra (butter milk) is advisable.
- If bleeding, instead of Suran, take black resins 30 to 40 each day.
- Old rice, wheat, Takra, Shunth (dry ginger powder), Padaval (snake gourd) etc. is good for piles.
- If Agnimandya (low digestive fire) and Pitta prakop (Vitiated Pitta) condition, then one should avoid Dairy products such as Yoghurt, Cheese, Paneer, Maida (white flour) and its products, mature Reddish, Carrot and Cucumber etc. as they are heavy to digest.

This review article attempts to simplify rectal prolapse management and touches maximum aspects of this embarrassing ano rectal
problem with an integrated prospective. The compilation revealing authentic and holistic management of rectal prolapse will be helpful to proctology practitioners and researchers.

REFERENCES

FIGURES

Figure 1. Rectal Prolapse
Dwivedi A, Pathrikar AA. An Integrative Review on 'Rectal Prolapse Management'.

Figure 2 Rectal Prolapse

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