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CASE REPORT

SPONTANEOUS RECTAL PERFORATION- A RARE PRESENTATION

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ABSTRACT

It is very usual to come across a case of acute abdomen with peritonitis in day to day surgical practice. Most often the cause of peritonitis is a hollow viscus perforation. Here we are reporting a case of patient coming to casuality with acute abdomen and peritonitis. X ray abdomen and ultrasongraphy was consistent with the diagnosis of perforation peritonitis and it was so on exploration, but the site of perforation was upper part of rectum without any pathology that is spontaneous rectal perforation which was very unusual in surgical practice.

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INTRODUCTION

Perforation peritonitis is a common entity in surgical practice leading to acute abdomen. Rectal perforation can be seen after trauma whether iatrogenic or external trauma and in case of previously diseased organ, but spontaneous perforation of rectum is rare as such (Tokunaga *et al*., 1998). Presentation of patient is similar to peritonitis due to any cause with classical symptoms of peritonitis. Early recognition and management is very important to prevent life threatening complications as severe fecal peritonitis leads to septicemia.

Case Report

A 54 yr old male patient admitted in casuality of PBM Hospital Bikaner, Rajasthan, India on 11-01-2015 with chief complain of pain abdomen for 10 days, inability to pass flatus and motion for 5 days and increasing abdominal distention with vomiting for 2 days duration. Pt having personal history of habit of drinking alcohol and smoking for past 20 years duration. There was no history of trauma/constipation/weight loss/ decreased appetite/ bleeding per rectum/ chronic left lower abdominal pain. On examination pt was conscious, oriented with blood pressure 100/62 mm of Hg, and temp of 101.9 F. On per abdominal examination generalized guarding and rigidity was present with rebound tenderness, per rectal examination revealed no intraluminal, mural or extraluminal growth palpable.

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Other systemic examinations were normal, bowel sounds were absent. X-ray flat plate abdomen showing free gas under right dome of diaphragm suggestive of perforation peritonitis. USG abdomen and pelvis was done showing mild free fluid with severe gaseous abdomen. An emergency exploratory laparotomy was performed, 500 ml of free fluid with feculent odour and feculent sediment drained with a 2.5 cm longitudinal x 2 cm transverse size perforation in anterior wall of rectum just above peritoneal reflection. There was no associated diverticular disease or mass palpable with condition of gut was satisfactory. Primary repair of perforation was done in single layer with 3-0 round body vicryl suture and a proximal loop sigmoid colostomy was done, abdominal wall was closed after putting an abdominal drain in rectovesical pouch.

DISCUSSION

The incidence of spontaneous perforation of rectum or sigmoid colon is very rare. It can occur in all age with youngest reported case being six years old and oldest ninety six years old (Schein and Decker, 1986). The perforation is often associated with a luminal pressure during defecation with a pre existing pathology such as diverticulosis, colitis, ulceration, malignancy, adhesions, irradiation, rectal and uterine prolapse, or as a consequence of iatrogenic injuries and biunt trauma to abdomen[1]. Chronic straining due to pre existing diseases causes progressive deepening of rectovesical and rectouterine pouches leading to thinning of rectal wall. Various theories have been proposed to explain the mechanism of perforation.

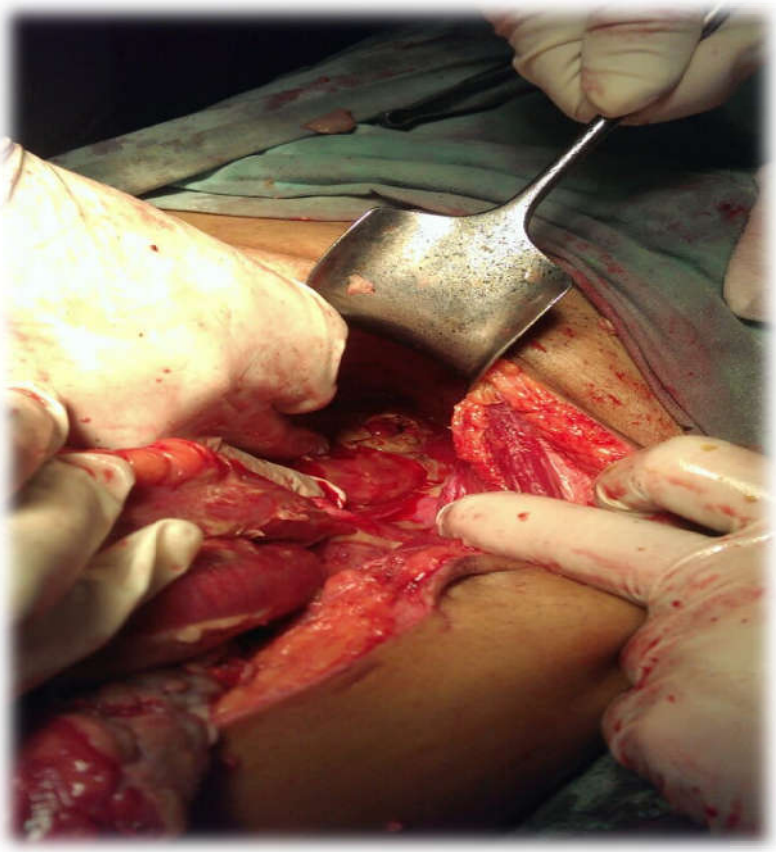

Figure 1. Showing rectal perforation in upper rectum

Among them most prevailing are: 1) intramural hematoma formation results in dissection and weakening of rectal wall, 2) congenital anal dysplasia co-existing with a weakened area of rectal wall and 3) progressive deepening of the pouch of douglas in combination with sudden increase of intra abdominal pressure could cause rupture of the rectum (Penopoulos *et al*., 2002). The perforation occurs in almost always in the distal part of colon because of the physiological characteristic of rectosigmoid colon such as lower water content of the stool, relatively poor blood supply and high pressure due to narrowed intraluminal diameter (Demirağ *et al*., 1993) and it involves the anterior wall of the rectum just proximal to the peritoneal reflection at the antimesenteric border of rectosigmoid junction (Demirağ *et al*., 1993). In most cases, it presents with diffuse peritonitis and X-ray chest shows air under subphrenic space. The treatment of this entity requires urgent surgical exploration with closure of the perforation and a diversion colostomy. The gut continuity may be restored after 3 months of surgery (Zhang *et al*., 2005). It is important to bear in mind that in patients with severe contamination, septic shock and delayed treatment, the mortality rate is over 60% (Hikita *et al*., 2001).

Conclusion

Rectal perforation without associated pathology is however a rare cause of peritonitis, prompt identification is necessary due to feared fecal peritonitis leading to septic shock and a very high mortality rate.

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