

# A case of small bowel evisceration through the rectum and anus

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## Abstract

A 46-year-old man presented with a small bowel prolapsing through the anus after straining on the toilet, which was starting to become ischaemic. He admitted to inserting a plastic object in his rectum about half an hour before straining. The bowel was kept moist by placing an intravenous drip line with saline dripping onto a wet swab. In theatre, the bowel was found to be prolapsing through a hole in the upper rectum and out through the anus. It was reduced back into the abdominal cavity through the same perforation, which was 4 cm long, without needing to extend it. This was sutured with polydioxanone (PDS) 2-0 as there was no contamination with faeces or pus. Due to improvement in the appearance of a small bowel and an extremely bruised mesentery, a re-look was planned in 24 hours. At the re-look the small bowel appeared healthy, therefore no resection was performed. However, a loop colostomy was fashioned to protect the upper rectal perforation repair. This shows that resection is not always required in such cases.

**Key words:** Evisceration; Rectal injury; Small bowel; Trauma

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## Introduction

A 46-year-old man presented to hospital with small bowel prolapsing through the anus, which occurred after inserting a plastic object in his rectum and straining on the toilet half an hour later. He was taken straight to the theatre for a laparotomy as the blood supply of the small bowel was compromised. There was a hole in the upper rectum through which the small bowel was prolapsing. It was reduced back into the abdomen. The hole in the rectum was sutured and as the blood supply had improved, no resection was performed. At re-look laparotomy 24 hours later a colostomy was performed.

## Case report

A 46-year-old man presented to the accident and emergency department in severe pain and with bowel prolapsing through the anus. This occurred when he was straining on the toilet. On closer examination, it was noted that the bowel coming through the anus was small bowel and starting to become ischaemic. On further questioning, he admitted to inserting a plastic object in his rectum, which was rather sharp, about half an hour before straining.

He was therefore taken straight to theatre for a laparotomy as the blood supply of the small bowel was obviously compromised.

A midline laparotomy was performed. The small bowel was reduced back into the abdominal cavity and packed away in a warm swab. The rectum was examined and a 4 cm hole was seen in the upper rectum. There was no contamination with faeces or pus, therefore it was sutured with polydioxanone (PDS) 2-0. By this time the small bowel was looking less dusky however the mesentery was extremely bruised. As there was improvement a decision was made to close and re-look in 24 hours.

He was kept intubated overnight in intensive care and was taken back to the theatre the next day. At this point the small bowel appeared pink and healthy, with active peristalsis, therefore no resection was performed however a loop colostomy was fashioned to protect the upper rectal perforation repair.

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His stoma started working within 48 hours postoperatively and he was sent home a few days later when he was fully stoma-trained. His stoma was reversed successfully about 4 months later.

## Discussion

This is a rare condition with less than 100 cases described in the literature. There have been some cases where patients with a previous history of rectal prolapse or uterine prolapse eventually develop spontaneous rectal perforation and small bowel evisceration through the anus (Jeong et al, 2000; Shoab et al, 2007; Kumar et al, 2013). These patients sometimes also require small bowel resection due to ischaemia, as well as a Hartmann's procedure due to rectal perforation and soiling, which was avoided in this case due to prompt management and transfer to theatre as well as lack of intra-peritoneal soiling (Gheewala et al, 2019; Hajiev et al, 2021). This patient also did not have any history of rectal prolapse unlike most of the other cases reported (Hajiev et al, 2021). There have been three prior cases without a history of prolapse or prolonged constipation (Al-Abkari, 2000; Mori, 2003; Papapolychroniadis et al, 2004). Most patients also deny any history of trauma to the rectum, which our patient did have (Al-Abkari, 2000; Farda et al, 2021). Management is highly dependent on clinical presentation, and in fact, before laparotomy the options discussed included resection of the upper rectum, in the form of a Hartmann's procedure as well as small bowel resection. Intra-operatively it was decided this was not appropriate as there was no contamination whatsoever. Imaging was not felt to be helpful in this case due to obviously compromised small bowel therefore he was operated on immediately.

### Learning points

- Imaging is not always helpful in such cases as the small bowel had a compromised blood supply, so getting to the theatre as quickly as possible was the main concern.
- Resection in such a case is not always required, especially when there is no contamination with faeces and the blood supply improves within a short period of time intra-operatively.
- Primary repair worked well in this patient, though a loop colostomy is helpful in cases such as this to mitigate the effects of leakage from a repair.
- This case is unique in that it is trauma-related with no previous known bowel pathology such as rectal prolapse.

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### Availability of data and materials

All the data of this study are included in this article.

### Author contributions

AF drafted the initial manuscript and performed a literature review. DS designed the project and edited the discussion. DM edited the manuscript for publication, assisted with the literature review and supervised the project overall. All authors contributed to important editorial changes of important content in the manuscript. All authors read and approved the final manuscript. All authors have participated sufficiently in the work and agreed to be accountable for all aspects of the work.

## Ethics approval and consent to participate

The patient consented to the case write-up.

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## Conflict of interest

The authors declare no conflict of interest.

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