

Mucocele of the Rectum

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Abstract: Mucocele of the rectum causing intestinal obstruction is a rare complication of retained long rectal stump. We present one such case.

Keywords: Mucocele of Rectum, Long Rectal Stump, Intestinal Obstruction

INTRODUCTION

The mucosa of Rectum secretes mucus, which must drain out otherwise it will accumulate over time. Injury, scarring and stenosis of the anal canal in a proximally closed rectum can cause mucocele. Which progressively enlarges in size.

CASE REPORT

A 45 yrs old male presented with vomiting, low grade fever, diffuse pain & distension of abdomen with constipation of one week duration. History of road traffic accident in October 1991, for which a sigmoid end colostomy with closure of distal bowel loop with supra public cystostomy done as emergency surgical procedure for pelvic fracture with damage to lower rectum & anal canal including sphincter.

On examination the patient was febrile 100 F, Tachypneic, pulse rate:- 96/min & mildly dehydrated. Abdomen was distended & tense. Colostomy seen in the left iliac fossa and SPC catheter in the supra public area. Bowel sounds were absent. Colostomy examination was normal. Examination of perineum showed complete stenosis of the anal canal.

Plain X ray abdomen showed dilated large bowel loops & no bowel gas seen in the pelvic area. Ultra sound abdomen revealed grossly dilated fluid filled bowel loops suggestive of sub acute intestinal obstruction (Fig: 1).



Fig. 1 : Ultrasound showing grossly dilated fluid filled bowel loops

Blood routine was normal except low serum potassium (2.9 Meq/Lit).

The patient was initially managed conservatively for two days with nil per oral, IV fluids, correction of hypokalaemia, Ryle's tube aspiration & enema through the colostomy. Since the pain and distension increased, laparotomy was decided. Through left Para median incision abdomen opened. A huge cystic mass arising from the pelvis to the supra umbilical region seen. Small bowel adherent to the cystic swelling. The cystic swelling was compressing

on the colostomy loop causing obstruction. On mobilizing the swelling it was found to be the long stump that was closed during the earlier procedure. The inter bowel adhesions released. 800 ml of mucous fluid aspirated from the cystic swelling & sent for culture & sensitivity. The swelling shrunk completely relieving the pressure on the colostomy site. The end was brought out as a mucous fistula on the right iliac fossa. Post operative period was uneventful.

DISCUSSION

The mucosal lining of the rectum secretes mucus, which must drain otherwise it will accumulate over time. Inflammation, scarring, epithelialisation & stenosis with obstruction of the anal canal can produce a mucocele, which can increase in size enormously.

Mucoceles are commonly associated with the appendix, retained esophagus, gall bladder neck obstruction and cranial sinuses. Rectal mucoceles are rare. The first reported pediatric case was an extraluminal pelvic mucocele in a patient with an imperforate anus following an endorectal pull through operation with incomplete mucosal excision¹. There are case reports of rectal mucoceles following Hartmann's procedure² for ulcerative colitis, and secondary to high anal sphincter tone following spinal trauma^{3,4}. Mucoceles have developed in defunctioned colon after pull-through surgery for Hirschsprung's disease⁵ due to stenosis and retraction of the colonic stump^{6,7}. Scarring of the mucus fistula, or failure to create a mucus fistula are other described contributing factors. Treatment requires effective drainage or removal of the mucus-producing epithelium.

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LITERATURE REVIEW

PREVALENCE AND PATTERN OF USE OF INDIGENOUS MEDICINES IN DIABETIC PATIENTS ATTENDING A TERTIARY CARE CENTRE

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The aim of the study was to see the pattern of use of indigenous medicines in diabetic patients and to find out its correlation with various demographic variables in patients of type 2 diabetes. A sample of 113 patients with diabetes (type 1 and type 2) was interviewed using a structured questionnaire by trained medical personnel about the intake of indigenous medicines. Correlation of intake of indigenous medicines with various demographic variables was assessed using appropriate statistical tests. Male to female ratio in the present study was 1:3. Mean duration of diabetes was 5.2 +/- 2 years. It was found that majority of patients 101/113 (89.4%) attending diabetic clinic were using indigenous medicines in one form or the other. Most common drugs used were karela (78.8%), jamun (65.5%), methi (38.9%) and neem (28.3%). Majority were taking on advice from fellow diabetics (41.6%) and were not sure (39.8%) about the effect. No significant correlation was found with their intake and demographic variables as age, sex, per capita income, duration of diabetes, occupation, cultural background and antidiabetic medicine used. There is a high percentage of indigenous drug use in patients with diabetes which is often not reported. Treating physicians need to be alert to this possibility while managing diabetic patients in order to correctly interpret glycaemic control, hypoglycaemic episodes and other unexplained comorbidities that might arise in them.