RECTAL PROLAPSE

objectives

1.Classify rectal prolapse
2. Enumerate the causes of rectal prolapse
3. Differentiate between complete rectal prolapse and intussusception
4. List the modalities of treatment

RECTAL PROLAPSE

Common condition.

Intermittent mucosal ---------- spontaneous

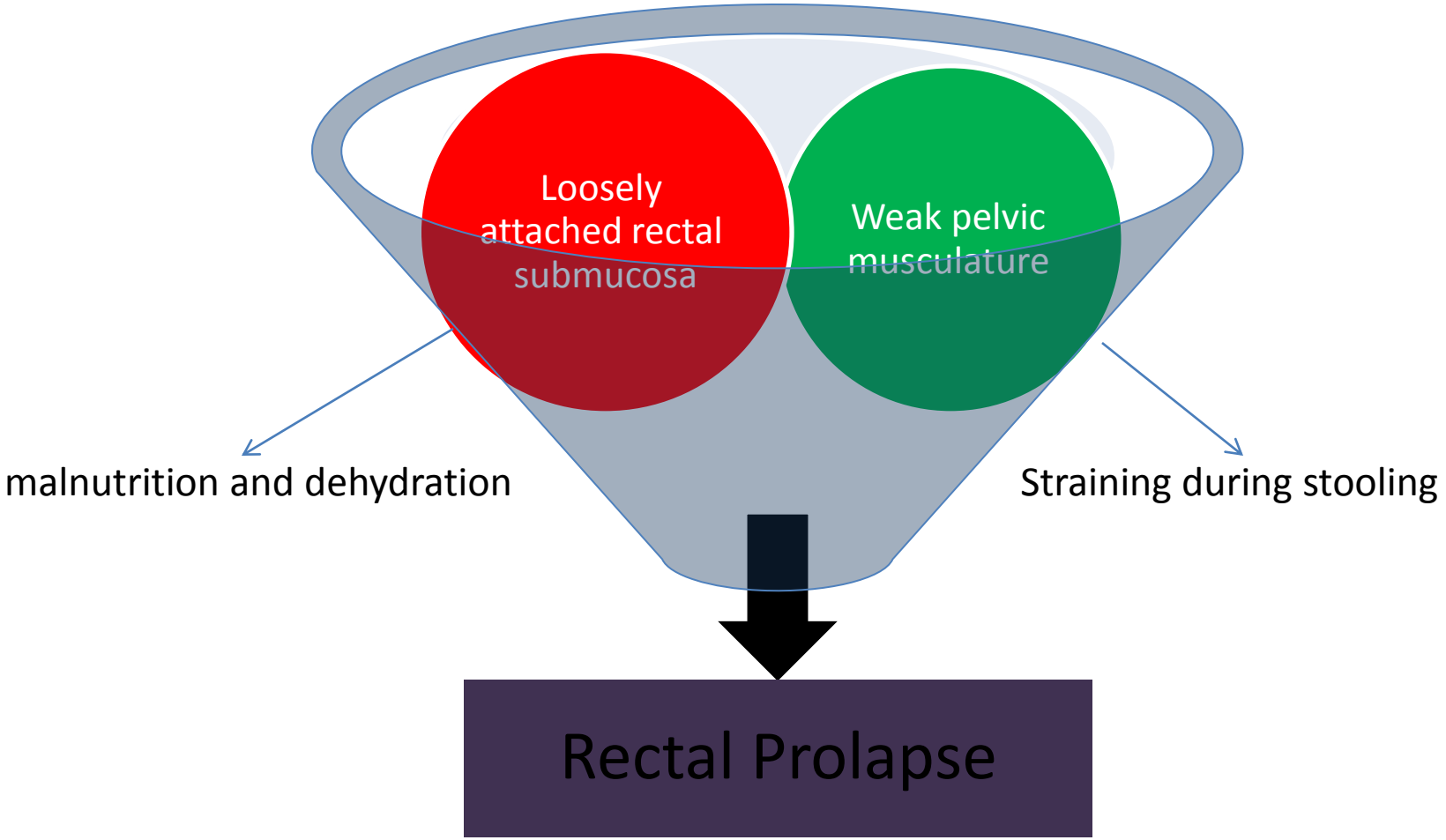
Full-thickness ---------- manual

Irreducible ??!!!!! ---------- vascular compromise

Uncomfortable to the parents and the child

CF ????

Aetiology


Loosely attached rectal submucosa
Weak pelvic musculature
malnutrition and dehydration
Straining during stooling
Rectal Prolapse

C/F:
mucosal rosette prolapse
Bleeding can occur
Mother reduce the prolapsed rectum
Older children learn quickly how to reduce it
Longer post. More than ant.
Rectal prolapse X Sigmoid intussusception ???
Look for lateral sulcus ???? 2 cm

Treatment:

»Conservative

1. Improve the nutrition status
2. Stool softener
3. defecation in squatting position
4. Enzymatic supplement for CF

» Surgical

1. Perianal cerclage (Thersh op.)
2. Sclerotherapy in the retrorectal space
3. Open posterior rectopexy

Rectal bleeding

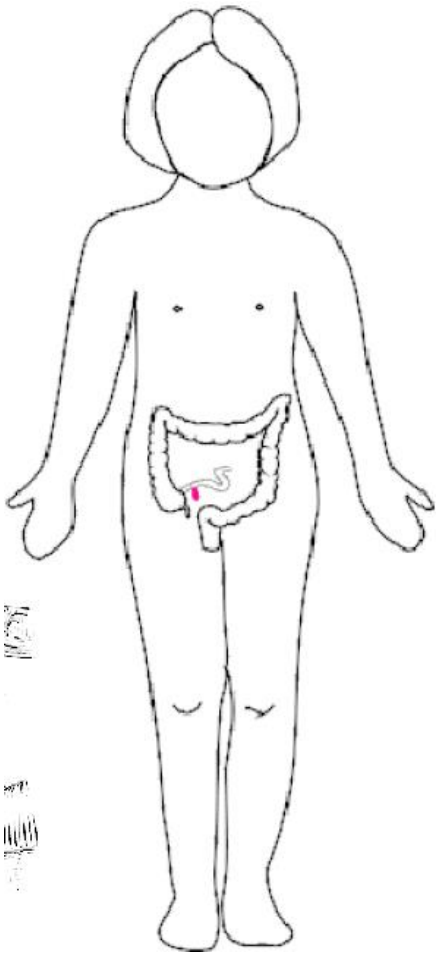
Aetiology:

depends on the age of the child, the type and quantity of bleeding and the associated symptoms.

Infants	Children
Fissure	Fissure
NEC	Juvenile polyp
Intussusception	GE
Allergic enterocolitis	Meckel's diverticulum
	Duplication cyst
	IBD

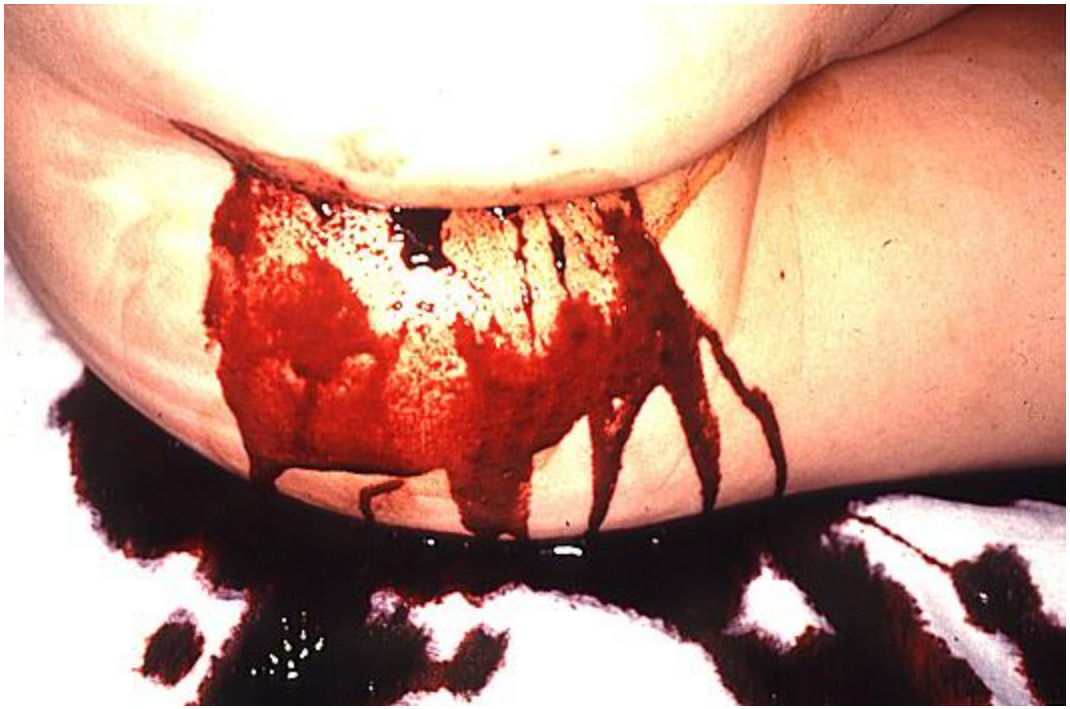
Meckel's diverticulum

Remnant of vitellointestinal duct which connect the midgut with the yolk sac.
Role of 2:
2% incidence
2yr. age
2 feet from ileocaecal valve
2 cm in diameter
2 inches length
2 common heterotrophic mucosa



Presentation → Bleeding
Intestinal obstruction
Inflammation

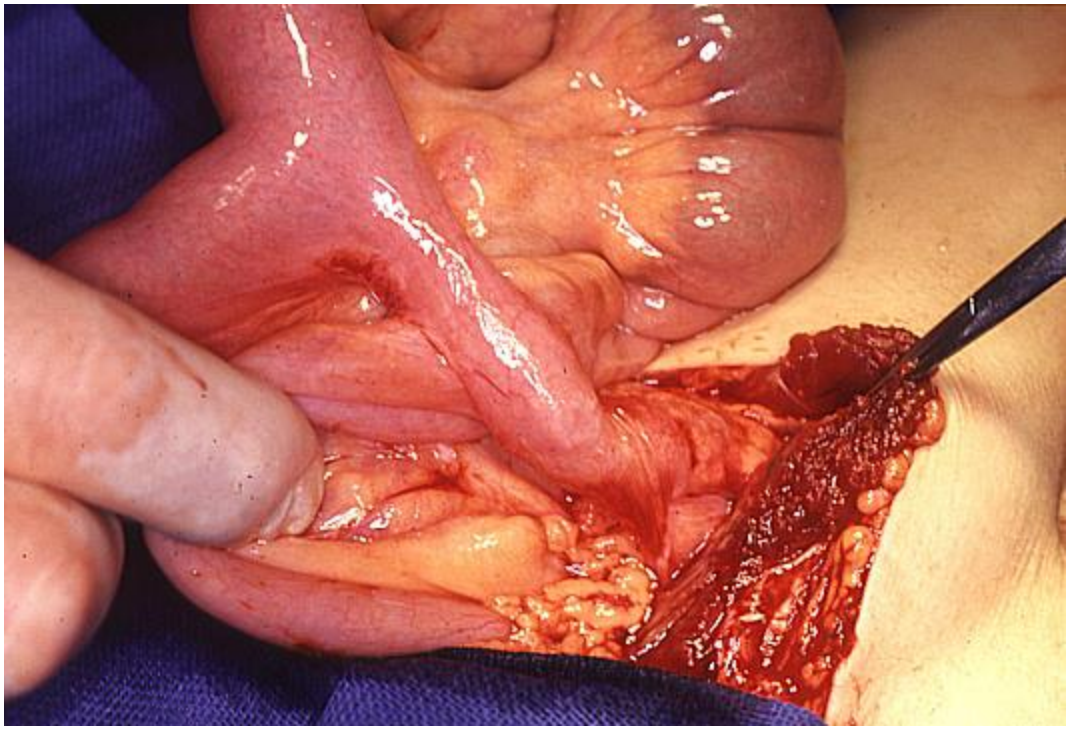
Bleeding:
due to gastric mucosa
ulceration
profuse painless rectal bleeding

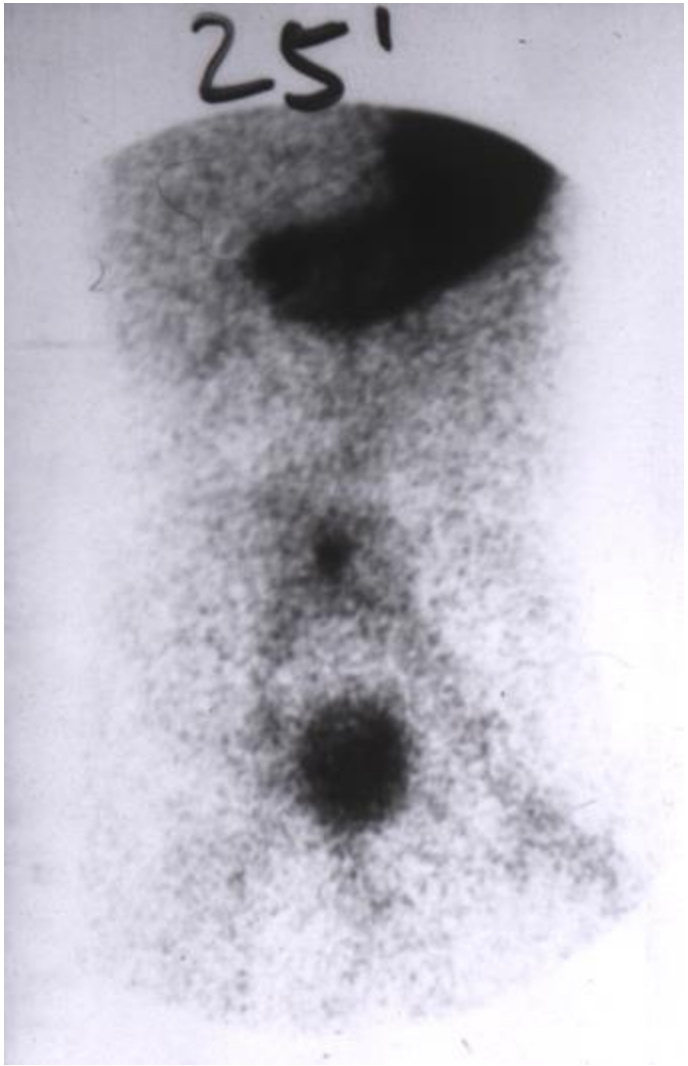


Dx.

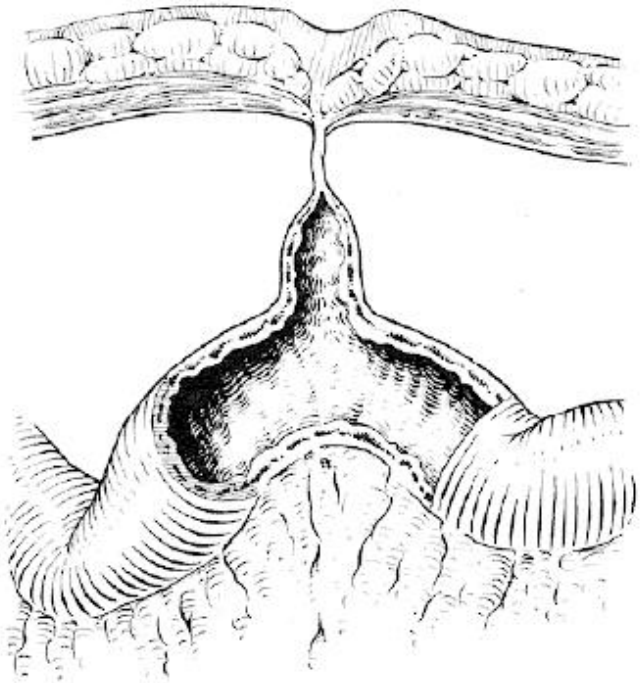
Technetium 99 scan

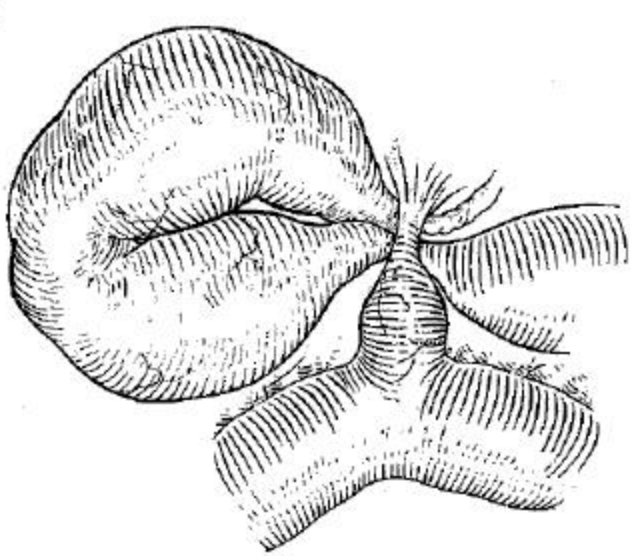
wireless capsule endoscopy

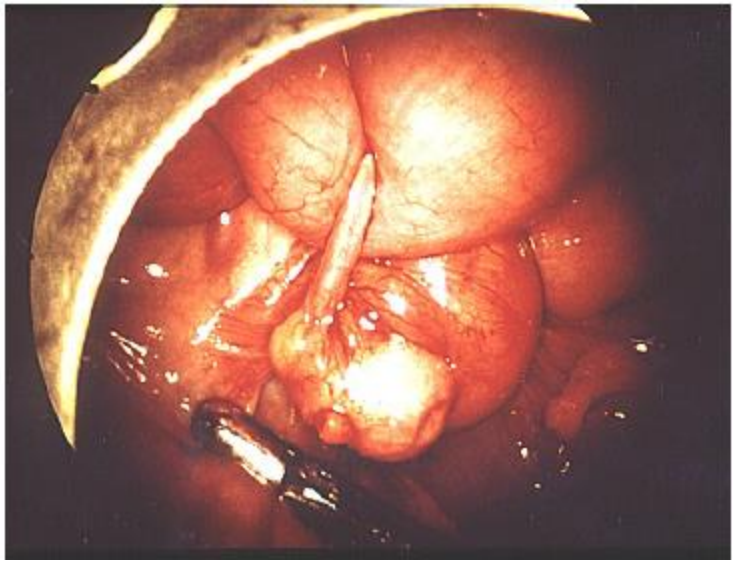




Intestinal obstruction:
Band
Intussusception
Volvulus
Perforation





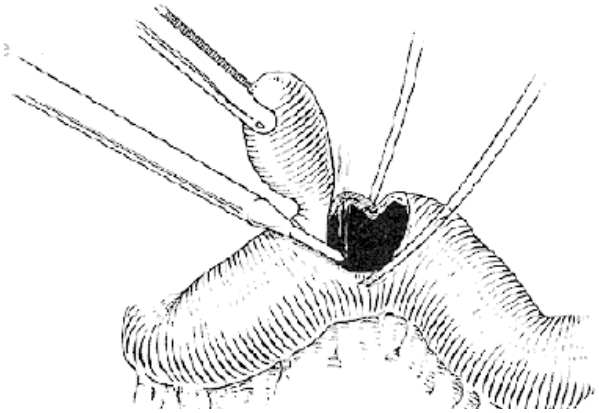


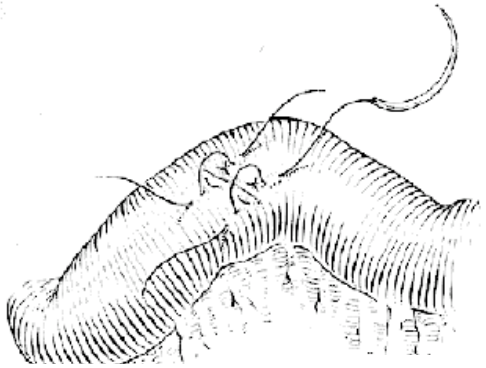
Diverticulitis:
mimics acute appendicitis but the nausea and vomiting is less prominent and the site of pain changes with movement.

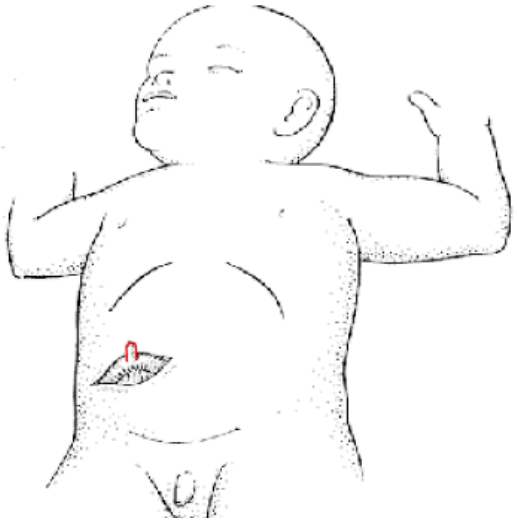
Usually the condition discovered intraoperatively

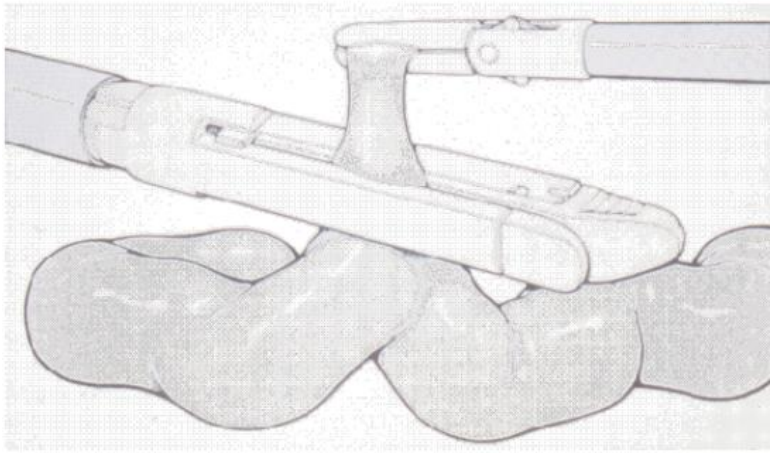
Treatment:

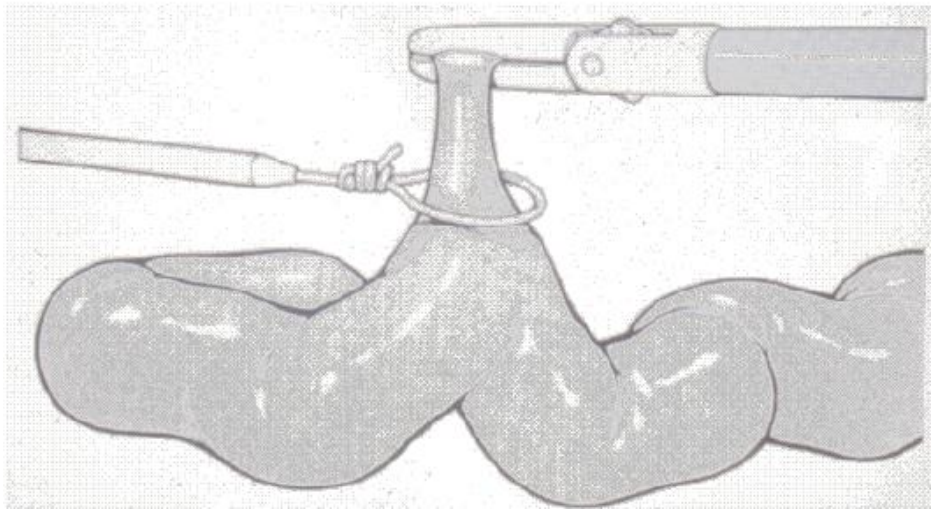
After resuscitation of the child the condition treated with complete wedge resection of the diverticulum with primary anastomosis, which is done either laparoscopically or open.







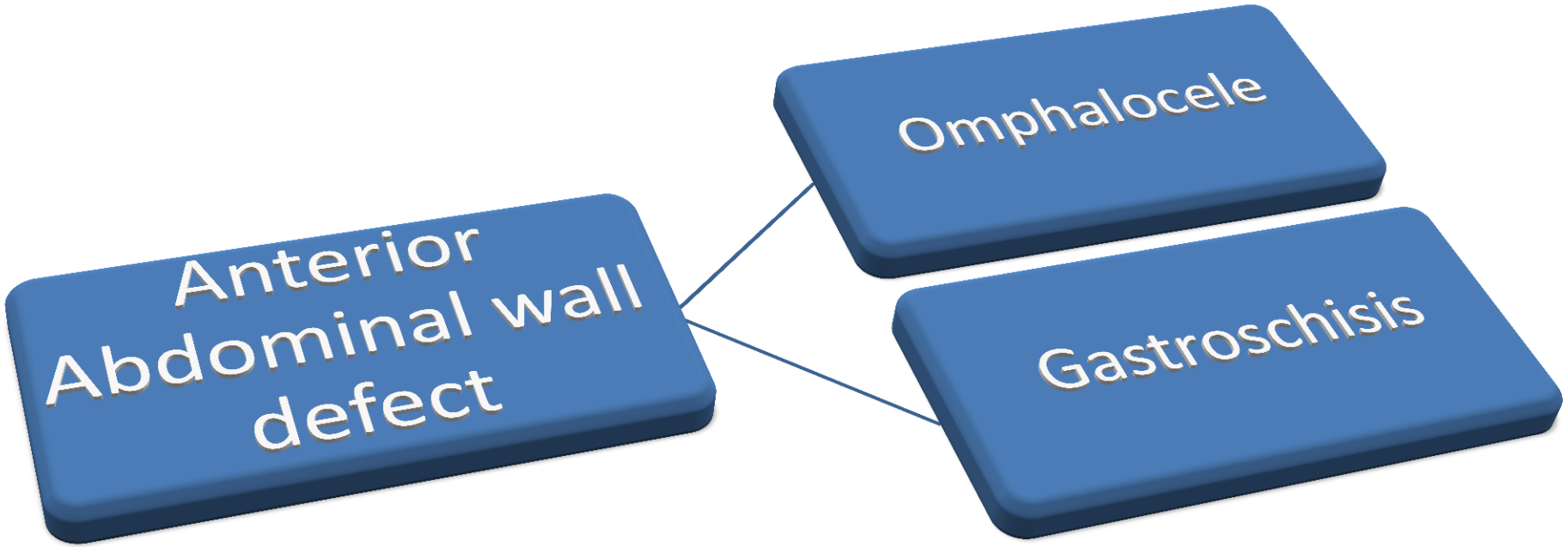




Abdominal wall defects

Usually they are diagnosed prenatally by ultrasonography.

Site ? Sac?



➢Omphalocele (Exomphalos)

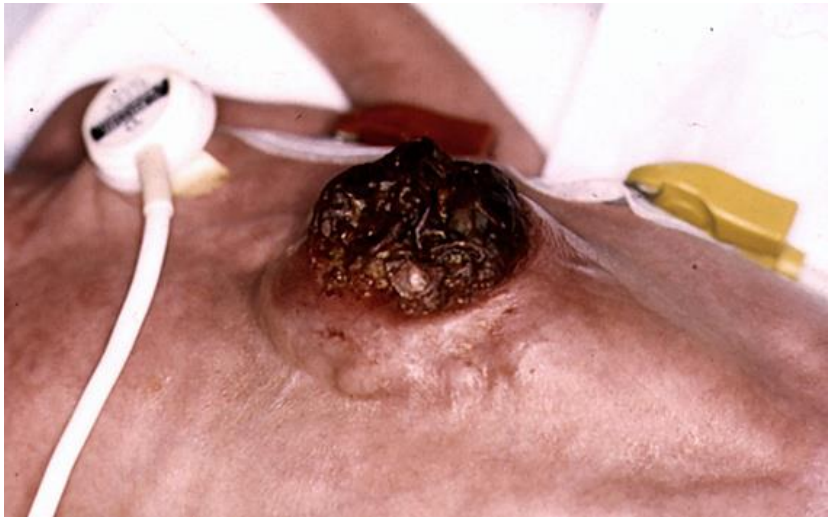
Associated cardiac abnormality 50%

High rate of chromosomal abnormality

long term outcome depends on associated abnormality.

The gut with/without the liver herniated outside the abdomen covered by a sac from which the umbilical cord arises.

Treatment depends on the size of the defect, gestational age, and associated anomalies.
There are many options for treatment starting from primary closure (small defect) to staged closure (big defect).

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➢ Gastroschisis

There is more incidence of intestinal anomalies (atresia)

In gastroschisis the gut is extruded through a defect lateral to the umbilicus (Rt).

The bowel are covered by a fibrinous peel instead of a sac, and they are foreshortened and non rotated.

The primary goal is to return the bowel into the peritoneal cavity

Treatment options include silo placement, serial reductions, and delayed abdominal wall closure, primary reduction with operative closure, and primary or delayed reduction with umbilical cord closure.

Delay in recovering gut motility

Good prognosis