

## **Posterior Sagittal Rectopexy for Rectal Prolapse**

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Rectal prolapse is common in pediatric age group. In children it is a much more benign process than in adults and therapy is correspondingly conservative. However, in an occasional child who has failed to improve with lesser forms of management, operative repair becomes necessary. We report our experience with a child who had rectal prolapse after excision of sacrococcygeal teratoma. This rectal prolapse did not respond to the routine measures and was treated by posterior sagittal rectopexy. This procedure involves modification of Ashcraft procedure(1) applying the posterior sagittal anorectoplasty approach as popularised by deVries and Pena for the repair of high imperforate anus.(2).

### **Case Report**

A 2-year-old female child was admitted with clinical diagnosis of complete rectal prolapse. The child was previously operated at another hospital in the neonatal period for sacrococcygeal teratoma. Details of previous surgery were not available. Examination revealed a lax, anteriorly placed anus. This was associated with com-

plete rectal prolapse which measured about 7 cm. Although the rectum could be easily repositioned, but in the absence of any rectal support, the child could not retain it in its place. The buttocks were flat and the muscles in the region were very attenuated. Conservative measures including repeated Thiersch's wiring was tried for over a year without success. So, an operative repair through posterior sagittal route was planned.

With the patient prone, in semijack-knife position, a mid sagittal skin incision was made from the midsacrum down to the anus. The dissection was then continued through the underlying levator ani and the striated muscle complex right down to but not through the external sphincter. The rectum was devoid of its major supports from the pelvic floor muscles. Once the rectum was completely freed from the surrounding tissues, the redundant posterior wall of the rectum was plicated. Few 5-0 silk sutures were then placed between the wall of the upper rectum and the presacral fascia. This was followed by reconstruction of the striated pelvic musculature as described by deVries and Pena(2), using 3-0 vicryl interrupted sutures. Few sutures incorporated the seromuscular portion of the posterior plicated rectal wall. The post-operative period was uneventful. The child is under regular follow-up and after 1½ years, he is doing well, with no problems of prolapse, constipation or incontinence.

### **Discussion**

Although conservatism is the hallmark of treatment of rectal prolapse in children, an occasional patient with a large and persistent prolapse will require surgical repair. A child previously operated for sacrococcy-

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geal teratoma with its attenuated muscles in this region is quite prone for complete rectal prolapse. In such an instance, the surgeon may employ any one of a number of operations that have been described in the adults. Most of the operative procedures usually done in adults are of considerable magnitude and may be attended by significant morbidity. As a result, there is reluctance to apply these techniques in children.

In our case, we have incorporated three different concepts. First, the posterior wall of the rectum was fixed posteriorly to the striated muscle complex and the levator ani carefully repaired in posterior sagittal anorectoplasty for high imperforate anus. Secondly, fixation of the rectum cephalad and posteriorly in the hollow of the sacrum was done. Thirdly, we also plicated the posterior wall of the dilated rectum. The latter helps not only in eliminating rectal prolapse, but also allows the overstretched sphincters and pelvic supporting tissues to regain their tone(3). This procedure has many advantages: elimination of laparotomy, more direct approach, excellent exposure, reconstruction of the attenuated and stretched sphincter muscles, and minimal morbidity and incapacitation.

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## An Unusual Presentation of Infantile Gangrenous Acalculous Cholecystitis

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Cholecystitis is rarely seen in infancy. Only a few cases(1-3) have been reported so far. The diagnosis of infantile cholecystitis is extremely difficult and most of the cases reported were diagnosed only at operation.

## Case Report

A 6-month-old male child weighing 4.5 kg was admitted with a history of high swinging temperature, pain abdomen, vomiting and absolute constipation for 5 days. The baby was toxic, dehydrated and febrile (103°F). The abdomen was distended, tender and generalised muscle guarding was present. The bowel sounds were absent. Per rectal examination revealed empty rectum. The hemoglobin was 7 g/dl, total leucocyte count was 12000/cu mm with 78% polymorphonuclear leukocytosis. A plain X-ray abdomen showed hazi-

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