Case report

Surgical treatment of anal incontinence after cure of a post-partum recto vaginal fistula: a case report from the "A" surgery department of the Ibn Sina hospital in Rabat.

Abstract

Anal incontinence is defined as the repeated involuntary release of rectal contents (solid or liquid faeces, gas, or mucus and phlegm) in patients aged over 3 years and who have been incontinent for at least one month. In women, the most common cause is obstetric trauma. Diagnosis is based on endoanal ultrasound and anorectal manometry.

We report the case of a 48-year-old woman who underwent surgery for a recurrent rectovaginal fistula and developed post-operative anal incontinence. The diagnosis was made by endorectal manometry. We treated the patient surgically with direct sphincter repair, and the post-operative follow-up was straightforward.

However, despite the fact that this condition is considered shameful, it is still necessary to talk to a specialist in order to obtain the best possible management and a better quality of life.

Keywords: anal incontinence -postpartum- a taboo subject -manometry- sphincterorrhaphy

1. INTRODUCTION

Anal incontinence is defined as the repeated involuntary release of rectal contents (solid or liquid faeces, gas, or mucus and phlegm) in patients aged over 3 years and who have been incontinent for at least one month [1].

Faecal incontinence is a physical, psychological, social and professional handicap, making the patient afraid of every act of daily life and gradually forcing him to confine himself [2].

When gas emission is frequent, isolated incontinence affects patients' quality of life and requires treatment equivalent to that for total faecal incontinence [3,4].

The main causes are anatomical defects of the sphincter, obstetric and pelvic trauma, and iatrogenic lesions (lateral sphincterotomy, fistulotomy, haemorrhoidectomy and anal dilatation manoeuvres).

Diagnosis is based on endoanal ultrasound and anorectal manometry.

Four surgical techniques are used in most patients after failure of medication and rehabilitation methods: sphincterorrhaphy, sacral root neuromodulation, and the two replacement techniques which are artificial sphincter and dynamised graciloplasty. Direct sphincter repair is the technique most commonly used in the surgical treatment of anal incontinence caused by sphincter injury [5].

2. CASE REPORT

We report the case of a 48-year-old patient who underwent surgery in 2017 for a recurrent post-partum recto-vaginal fistula and difficulty containing gas, and who presented with postoperative anal incontinence with a Jorge and Wexner score of 11.

Her history goes back 6 years, when after a dystocic delivery, for a fourth gesture, she presented with a recto vaginal fistula that had been treated twice. After 3 months, the patient noticed incontinence with gas, then with stools, for which she was embarrassed to talk about it and don't consult a doctor for several months. Finally, with the help of her husband, she decided to seek treatment.

On physical examination, we noted an anal gap and a reduction in the ano-vaginal space. On rectal examination, particularly endorectal manometry, there was a loss of sphincter tone both at rest and when the sphincter was contracted.

A standard biological work-up (CBC, haemostasis and ionogram) was carried out and was almost normal.

The patient was scheduled for reconstructive surgery and underwent anterior sphincterography, reinforced by bringing the lift muscles of the anus closer together.

Fig 1: Transverse incision of the perineum (ano-vulvar space)

Fig 2: repérage des deux bouts des muscles releveurs de l'anus

3. DISCUSSION

Several epidemiological studies have shown that the prevalence of anal incontinence is high.

A review of the literature has shown that the prevalence rate of anal incontinence in different countries varies from 3% to 17%, with wide variations essentially due to the definition of incontinence (which may or may not exclude simple gas incontinence), the nature of the population studied and the method of data collection [6].

A French regional study published in 1992 by Ph. Denis et al [7] found that, in a sample of 1100 subjects aged over 45, 11% suffered from faecal and/or gas incontinence (18% had at least one episode of faecal incontinence per week). This rate rose to 33% when the same research was carried out among 10,157 elderly people living in retirement homes or nursing homes. Our patient, aged 48, fell into this age category and presented with anal incontinence. However, in relation to frequency, we believe that there is an underestimation of cases of anal incontinence in the population, the disease being considered a taboo subject by most patients who develop it.

The prevalence of postpartum anal incontinence varied according to the studies from 4% (primiparous) to 39% (multiparous) at 6 weeks postpartum, while faecal incontinence could reach 8 to 12% respectively at 6 years postpartum [8]. The original study by St Mark's Hospital [9] prospectively analysed a cohort of 79 primiparous women and 48 multiparous women who had given birth vaginally. These data corroborate our case report of a multiparous woman at her fourth parity out of 4 gestations, with a dystocic vaginal delivery which caused firstly a rectovaginal fistula and then anal incontinence.

Primiparous and multiparous women developed new incontinence in 13 and 6% of cases respectively. The first birth was considered to be the most traumatic for the perineum [10]. Contrary to what these authors assert, our patient was in her fourth delivery, which was the most traumatic because of the presence of a large foetus, causing a recto-vaginal fistula, which, by dint of being repaired (recurrence),

was complicated by anal incontinence, the sphincters having already been weakened by this delivery with difficulty in containing gas earlier. The questionnaires and scores most frequently used in studies to assess anal incontinence are: the Wexner score [11], the Pescatori score [12], the Saint-Mark's Hospital score [13], the Rockwood score [14] and the Osterberg score [15].

In our study we used the Wexner score [11] to assess anal incontinence using the simple questions proposed by Villot A. et al [8]: "In the last 4 weeks, have you had at least one episode of gas leakage or stool loss? The majority of authors considered that anal incontinence existed as soon as an episode was reported in the last 4 weeks.

4. CONCLUSION

Anal incontinence remains a taboo subject and is considered degrading.

In women, the most common cause is sphincter injury due to obstetric trauma, and in this case, direct sphincter repair is the most commonly used technique.

Whatever the cause, it is always advisable to discuss the problem with a specialist doctor, so that the best possible care can be taken to improve quality of life.

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