Conservative Management of Rectal Ischemia

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Introduction
Rectal ischemia is a rare condition, because there are abundant collateral vessels supplying it. The surgical treatment of ischemic proctitis is controversial.

Case Report
We present the case of an institutionalized 78-year-old woman, admitted at the emergency department for a syncopal episode after profuse rectal bleeding. She has a personal history of senile dementia, arterial hypertension, ischemic heart disease with heart failure (ejection fraction lower than 30%), chronic renal failure and long-term constipation. The initial physical examination objective the presence of a large rectal fecaloma requiring manual disimpaction. After rectal lavage, rectosigmoidoscopy is performed in which extensive and circumferential rectal ischemia is identified (Figure 1).

Due to the high surgical risk, we proposed conservative management with intestinal rest and broad-spectrum empirical antibiotics for 2 weeks. The clinical and analytical evolution is satisfactory in the first 48 hours. Endoscopic examination is performed after 15 days, with mucosal integrity and residual fibrin tracts (Figure 2).

Discussion
Rectal involvement in colorectal ischemia is very rare, only in 2% to 5% of the cases. The blood supply of the rectum comes from the superior rectal artery which is a branch of the inferior mesenteric artery, middle rectal artery which is a branch of the internal iliac artery, and the inferior rectal artery which branches off the internal pudendal artery. The usual treatment in these cases is based on the more or less extensive surgical resection, depending on the segment involved. The morbidity of this type of interventions is very high, as a consequence of the technique, the emergency, the baseline condition of the patient (co-morbidities), age and history of risk factors for colonic ischemia. Emergency rectal resection might add additional risk to the primary procedure in an unstable patient, reaching up to 25% of mortality.

The rest of the colonic mucosa explored up to 30 cm of anal margin seemed healthy.
The exceptionality of this case, compared to all the other cases reported on the literature (Table 1).

<table>
<thead>
<tr>
<th>Publication</th>
<th>Type of publication</th>
<th>Affected segment</th>
<th>Causes</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darling RC, 2012</td>
<td>Case report</td>
<td>Rectal</td>
<td>Aortic reconstruction</td>
<td>Surgical</td>
</tr>
<tr>
<td>Majer A, 2014</td>
<td>Case report</td>
<td>Rectal</td>
<td>Unknown (cardiovascular risk factors, Salmonella infection)</td>
<td>Surgical</td>
</tr>
<tr>
<td>Didnée AS Jr, 2015</td>
<td>Case report</td>
<td>Rectal</td>
<td>Bilateral uterine artery embolization</td>
<td>Surgical</td>
</tr>
<tr>
<td>Mosley FR, 2016</td>
<td>Case report</td>
<td>Rectal</td>
<td>Abdominal aortic surgery</td>
<td>Surgical</td>
</tr>
</tbody>
</table>

Table 1: Review of the literature of the cases reported previously.

Lies both in the rarity of the entity and in the satisfactory evolution with conservative management, based on medical treatment. In this case, the extensive involvement of the rectal wall is attributed to regional hypoperfusion resulting from the compression produced by the large fecaloma [5].

Conservative management of rectal ischemia should be considered in those patients with a high surgical risk and isolated rectal involvement, re-evaluating the response in an analytical and clinical way, as well as endoscopic control in 1-2 weeks.

Conclusion

Rectal necrosis is rare clinical entity, poorly described in the literature. Clinical course may be life-theatering, because almost always lead to bowel obstruction or diffuse peritonitis, which are surgical emergencies.

To our knowledge, this is the first case of total rectal necrosis successfully managed by conservative treatment.

References