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A SIMPLE AND COST-EFFECTIVE APPROACH TO RECTAL PROLAPSE: A CASE STUDY OF THE THIERSCH PROCEDURE

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ABSTRACT
Rectal prolapse is a distressing condition characterized by the protrusion of rectal tissue through the anal canal, often resulting in discomfort, bleeding, mucous discharge and faecal incontinence. While multiple surgical techniques exist, the Thiersch procedure offers a simple and minimally invasive option, particularly suited for elderly or high-risk patients who may not tolerate extensive abdominal surgery. This article outlines the principles, indications, surgical technique, advantages, limitations and outcomes associated with the Thiersch method.

INTRODUCTION
Rectal prolapse is a condition in which the full thickness of the rectal wall protrudes through the anal canal. It occurs more frequently in elderly women. The disorder is classified into two types: complete (full-thickness) prolapse and incomplete (partial-thickness) prolapse. In complete prolapse, the entire rectal wall extends outside the anus and typically appears as concentric folds. In incomplete prolapse, the rectal wall protrudes only within the anal canal; this form is also known as occult rectal prolapse or internal rectal intussusception. In clinical settings, mucosal prolapse is often mistaken for rectal prolapse. Unlike rectal prolapse, mucosal prolapse involves only the rectal mucosa or a portion of the rectal wall rather than the full thickness and it must be distinguished because the surgical management differs. Rectal prolapse involves circumferential descent of the rectal wall through the anus. It is more common in elderly individuals and in patients with weakened pelvic floor support. Surgical correction remains the definitive treatment. Among perineal procedures, the Thiersch method provides a straightforward approach aimed at preventing further protrusion by mechanically supporting the anal canal.

CASE REPORT
A 46- year- old female patient attended the OPD of Shalya Tantra Department, Gopabandhu Ayurveda Mahavidyalaya, Puri with a complaint of a mass protruding from the anus during or after defecation with bleeding per rectum. Also, faecal incontinence with anal discomfort seen. Previously she had taken medications from a general practitioner but she had no relief so she came to our hospital for better treatment. He had no such family, medical history or any disease condition like Diabetes or Hypertension.

History of Present Illness
The patient had been in good health until about one year ago, when she noticed a mass protruding from the anus along with a small amount of bleeding during defecation. She initially consulted an allopathic doctor, who prescribed antibiotics, NSAIDs and a topical ointment. Despite following the treatment, there was no improvement in her condition. Seeking better care, she later visited the Shalya OPD of Gopabandhu Ayurveda Mahavidyalaya, where the doctors diagnosed her with rectal prolapse.

History of Past Illness
No such history found.

Family History
No relevant family history.

Treatment History
1.Tab Linezolid 1 tab BD A/F
2.Tab Zerodol-P 1 tab BD A/F
3.Cap Coolet -D 1 cap OD B/F
3.Oint T-bact for L/A
4.Syp Piolax 30 ml at bed time

Surgical History
- No history of any surgery found.

Personal History
- Marital status: Married
- Diet: Mixed
- Appetite: Poor
- Bowel: Mild Constipated
- Sleep: Sound
- Addictions: Nil
- Micturition: 5-7/day

General Examinations
- BP-130/88 mm/hg
- PR-79/min
- RR-14/min
- Temp.-98.6F
- Weight-66 kg
- Height-156 cm
- Pallor/Icterus- Absent

Investigations
- Hb % - 14.7 gm%
- BT- 1 min 24 sec
- CT- 3 min 58 sec
- Total WBC- 9500 Cells/CMM
- Differential count - Neutrophil- 64%

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Lymphocytes- 26%
Eosinophils-07%
Monocytes- 03%
Basophil- 0%

- ESR- 30 mm/hour
- RBS- 124mg/dl
- HIV- Negative
- HBSAG- Negative

DIAGNOSIS

On the basis of above clinical examinations, patient was diagnosed with Prolapsed rectum.

Principle of the Procedure

First described by Carl Thiersch in the late 19th century, the technique involves encircling the anal canal with a non-absorbable material to narrow the anal opening. This mechanical support prevents the rectum from prolapsing while allowing passage of stool.

Pre-Operative Procedure

Written informed consent was first obtained from both the patient and the attendant for the procedure and for publication of the case report. The patient was advised to take 2 tabs of MT -Pex at bedtime on the night before surgery. On the morning of the operation, a proctoclysis enema was administered. A sensitivity test using an intradermal injection of xylocaine was performed to check for any allergic reaction. Subsequently, a tetanus toxoid (T.T.) injection of 0.5 cc was given intramuscularly.

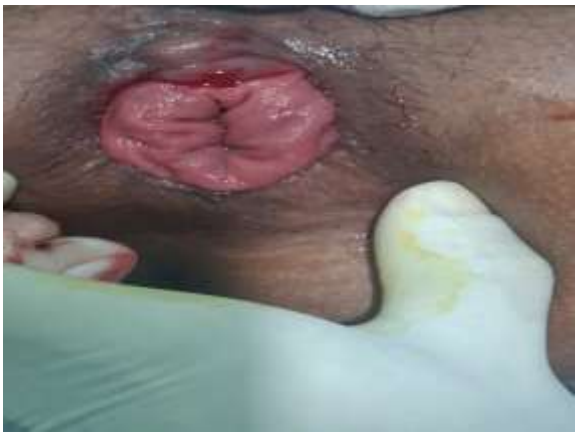
Operative Procedure

At first, place the patient in lithotomy position. Then ensure proper exposure of the perianal region & maintain aseptic precautions. Then Local anaesthesia given & infiltrate the perianal skin with lignocaine. Prolapse is gently reduce it using lubricated gauze and steady pressure & ensure complete reduction before proceeding. Identify a circular path about 1–1.5 cm from the anal verge. Then two small stab incisions made at anterior and posterior position. Use a curved artery forceps to create a subcutaneous tunnel around the anal canal. Then pass the non-absorbable material Prolene through the tunnel. Tie the material snugly to narrow the anal opening. Ensure it allows passage of two finger to avoid obstruction. Secure the knot subcutaneously & Close stab incisions. Apply antiseptic dressing. Confirm adequate anal opening. Check for bleeding or excessive constriction.

Postoperative Care

Postoperative care includes maintaining good perianal hygiene, using stool softeners and adopting a high-fibre diet to prevent straining. The patient should be monitored for infection, pain or faecal impaction and advised to avoid excessive straining during bowel movements.

RESULT



(Fig.1 – Before Procedure)

(Fig.2 – During Procedure)

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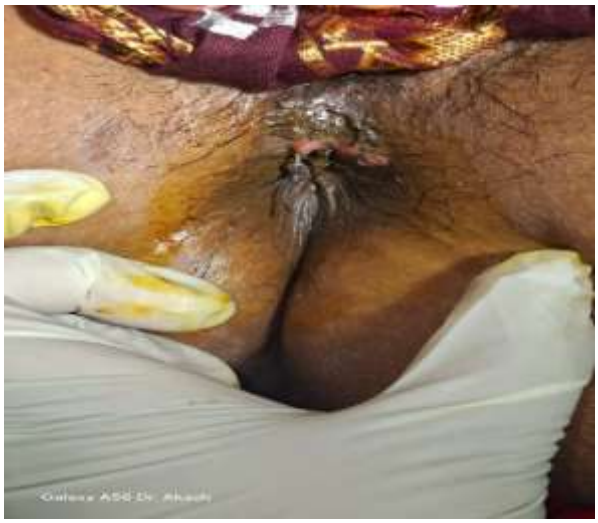

(Fig.3 – After 15 days)

(Fig.4 – After 30 days)

ADVANTAGE

Simple and quick procedure. Can be performed under local anaesthesia. Suitable for high-risk and frail patients. Minimal operative trauma and short recovery time. Cost-effective and technically straightforward.

DISCUSSION

The Thiersch method plays an important role in the management of rectal prolapse in patients who are not candidates for major abdominal surgery. While it does not correct underlying pelvic floor defects, it provides symptomatic relief and prevents protrusion. Proper patient selection and postoperative bowel management are essential to optimize results.

CONCLUSION

The Thiersch procedure remains a valuable surgical option for managing rectal prolapse in elderly and high-risk patients. Its simplicity, safety, and suitability under local anesthesia make it particularly useful in resource-limited settings and in individuals unable to undergo extensive surgery. Despite higher recurrence rates compared with abdominal procedures, careful patient selection and supportive postoperative care can provide meaningful symptom relief and improved quality of life.

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