Abstract: 52 yr female sustained abdominal trauma with rectal tear and evisceration of small intestine through anus was presented. Resection of Eviscerated Small Bowel and End to End Anastomosis done with Single Layer Suturing of Rectal Tear and Ileal Perforation Closure.

Keyword: Rectum tear, blunt injury, evisceration.

INTRODUCTION
Transanal evisceration of bowel loops is an alarming and rare presentation of rectal tear due to blunt trauma. A timely surgery can be life-saving in this potentially fatal injury. Rectal or Rectosigmoid perforation with transanal small bowel evisceration is a remarkable occurrence because of its rarity and extraordinary presentation. Less than 70 such cases have been reported in the English literature since the first recorded case in 1827 by Brodie.

CASE HISTORY
52yr old female came with history of accidental fall from the stairs, brought by their relatives with the complaints of abdominal pain and some thing descending through anus. On examination She had no airway or breathing problems. She had a blood pressure of 90/60 mm Hg and a pulse rate of 120/minute. She was conscious and oriented. There were no signs of intracranial compressing lesion. There was no chest injury. There was tenderness and guarding in the lower abdomen. There was no pelvic bone injury. The genitalia were normal. About 20 cm of distal ileum eviscerated out of the anal opening. There was no sign of injury in the perineum. Back and spine examination was unremarkable. PR not done for fear of bowel injury. PV normal. No external injury.

She was resuscitated; a nasogastric tube and a urethral catheter were passed. X-ray abdomen shows a Thin Strip of Air under the Diaphragm. The ultrasonographic examination revealed a collection in the pelvis. There was no injury to the liver, spleen and kidney. An emergency laparotomy was done through a lower midline incision. There was no hemoperitoneum.
About 500 ml Purulent Fluid present in the abdominal cavity. Prolapse of 2-3 Ft. S. Bowel per Rectum. Tear in the Ant. Rectal Wall (middle/3) of 5cm. And 5 mm Solitary Perforation in Terminal ILEUM. The bowel prolapsed was congested and found to be unhealthy. The eviscerated small gut was reduced after proper cleansing. Peritoneal Toileting with Resection of Eviserated Small Bowel and End to End Anastomosis done with Single Layer Suturing of Rectal Tear and Ileal Perforation Closure. The patient had an uneventful recovery.

**DISCUSSION**

Rupture of rectum following blunt abdominal trauma occurs due to sudden sharp rise of intra-abdominal pressure at the time of impact. The pressure forces the freely mobile bowel loops through the rent. When the pressure is sustained over a long period of time, the loops travel through the rectum to present outside. The sealing effect of the prolapsing loops of intestine limits the peritonitis. Eviscerated bowel should be kept warm and moist by wrapping it in warm moist packs. The bowel should be carefully reduced from the anus and preserved if viable. Resection was necessary in our case as a result of extensive mesenteric stripping leading to bowel gangrene. The rent in the rectum which is usually longitudinal and in the anti mesenteric border should be repaired and other associated injuries repaired. The use of a proximal diverting colostomy to protect the repaired rectum should be selectively performed on the basis of the patient condition, degree of fecal contamination and severity of the rectal injury. In most cases, there is little fecal contamination because the prolapsed loops of small bowel effectively plug the rent in the rectum, thus preventing fecal spillage. All patients of transanal evisceration require surgical management. As long segments of small intestine may be denuded off the mesentery, resection anastomosis of the non-viable bowel may be required. A colostomy should be done selectively depending on the nature of rectal tear, presence of contamination; time elapsed after injury and general condition of the patient.

**REFERENCES**


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