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Case Report

Congenital Repeated Anus: A Case Report

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ABSTRACT

Repeated anus is a rare congenital condition characterized by repeatedly discharging of faeces and gas in the fistula. Its presentation is long-term. We herein report a rare presentation of the disease in a 45-year-old Chinese woman. Preoperative examination and postoperative medical examination confirmed the diagnosis we made was at first. The patient underwent surgery. Recovery was ideal.

Case Report

A 33-year-old woman associated with an open perianal fistula，intermittent discharge of feces and gas after birth. These symptoms happened repeatedly and became severe when she suffered from diarrhea. So, she paid much attention on what she ate, such as not eating raw or cold food, overeating. The fistula was discovered by her mother 20 days after birth when her mother suddenly found that there was another excretion closing to the normal anal with feces. According to hearsay, it may be a complication about congenital anal atresia, taking surgery at that age may affects fertility. Bearing a sense of social responsibility, she didn't take any measures for 33 years. Now the mother of 2 children, a girl and a boy, decided to solve this disease. Though symptoms seem severe, it didn't affect sleeping time or quality, urine's volume or frequency and appetite. And we did not find any same symptoms in her parents, her children or the brother of the same mother and father.

Physical examination revealed that a fistula was at 11' o clock in the lithotomy position, about 4cm away from the anal margin, about 2.5cm*3.0cm skin defects, round-like, a tubular channel that leads to the anus at 11'o clock 4cm along the subcutaneous and sphincter muscles with a round-like 3.0cm*3.5cm internal mouth (Figure 1). There was no reachable mass in the rectal anal canal. Medical imaging tests showed as follows: Iodine water enema showed that a 21*17mm pouch shadow is visible on the anterior wall of the rectum. The upper end shows a 17mm long and 8mm wide tubular shadow connected to the rectum. The lower opening is located under the skin and the contrast agent can be seen flowing out. The conclusion of the test was repeated anal deformity. Computed Tomography (CT) showed that there is a long tube-like structure on the right side of the anal canal leading to the right perianal subcutaneous, about 30mm in length, and a ring-shaped strengthening after injecting contrast agent. The conclusion of CT was right perianal sinus formation and suggested Magnetic Resonance Imaging (MRI) test. The MRI test showed that the inner mouth is located at the 11 o'clock direction of the stone 4mm from the anal edge. The sinus diameter is about 3mm. After operation, we sent the resected tissue for the pathological examination. It showed proliferation of squamous cell epithelium, fibers, blood vessels and muscle tissue. (Figure 2)

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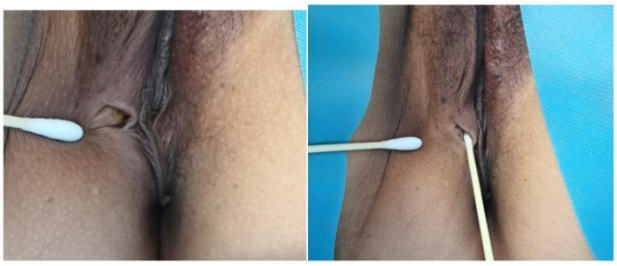


Figure 1: Physical examination shows a fistula at 11' o clock in the lithotomy position.

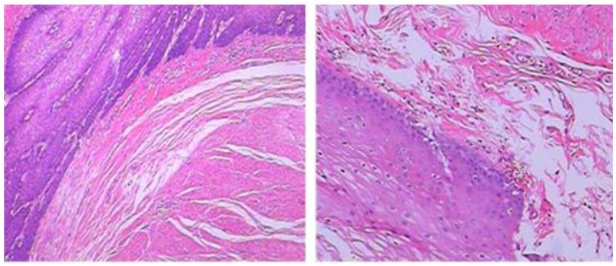
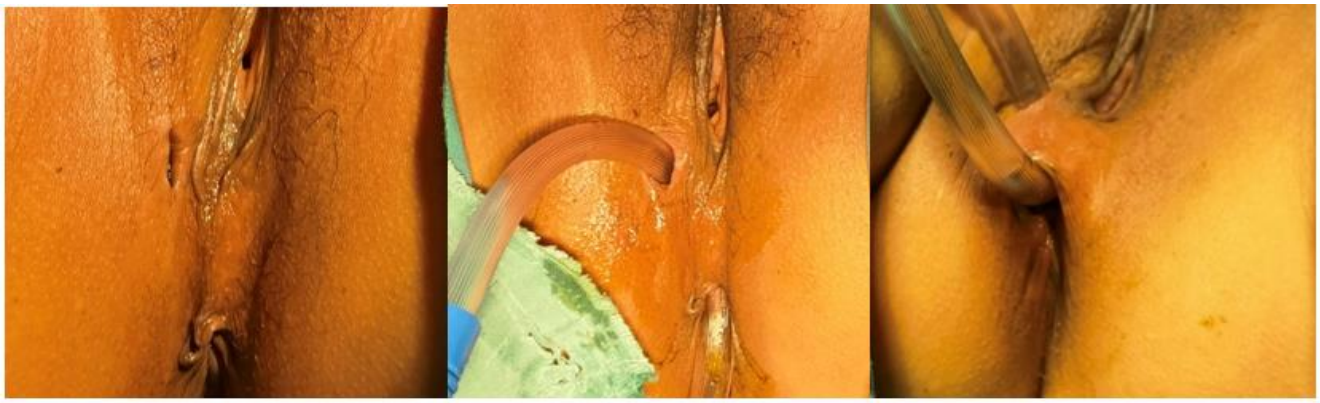


Figure 2: Tissue seen under the microscope include squamous cell epithelium, fibers, blood vessels and muscle tissue.

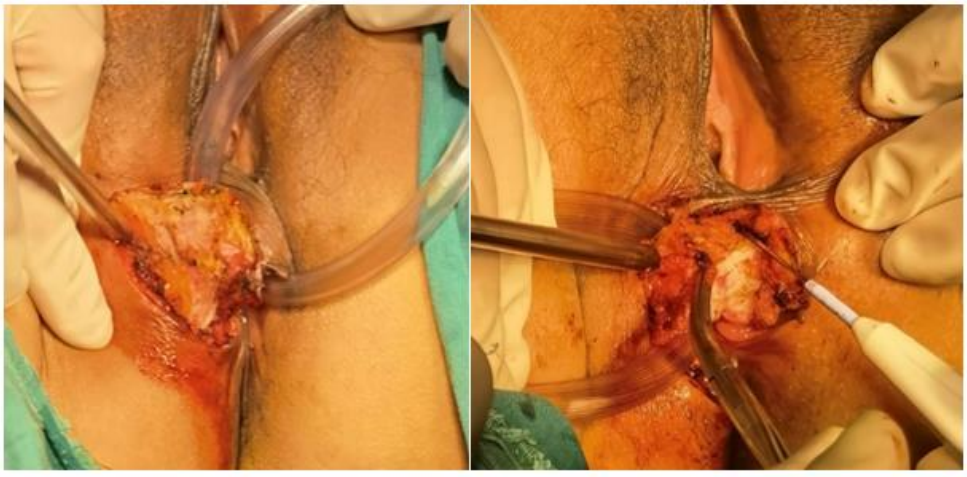
What to Do Next?

In several days of discussion, we combined the existing conclusions of various aspects and the patient's own wishes. We decided to adopt surgical treatment. The specific surgical procedure was needed to be determined during the operation. After the anaesthesia, we re-examined the patient's condition in the lithotomy position. The external mouth was visible at 11 o'clock from the anal margin. In (Figure 3A) there was no redness or ulcer on the local skin. The plastic hose was used to penetrate from the external port, and the hose can be led out from the internal mouth (approximately 1cm from the anal edge) (Figures 3B & 3C). We carefully explored the fistula. It was superficial to the skin and had no muscle bundle palpation. We evaluated the feasibility of fistula resection. Before resection, we flushed the fistula and skin surface with complex iodine water and cut the skin along the fistula to protect the surrounding tissue (Figures 4 & 5). After completely freeing the fistula (Figure 7), we flushed the surgical field to clean, and then made several layers of the intermittent suture with absorbable thread on the anal canal and skin surface (Figures 6A & 6B). In the end, we disinfected the wound with complexed iodine and inserted the anal canal for drainage (Figure 6C).



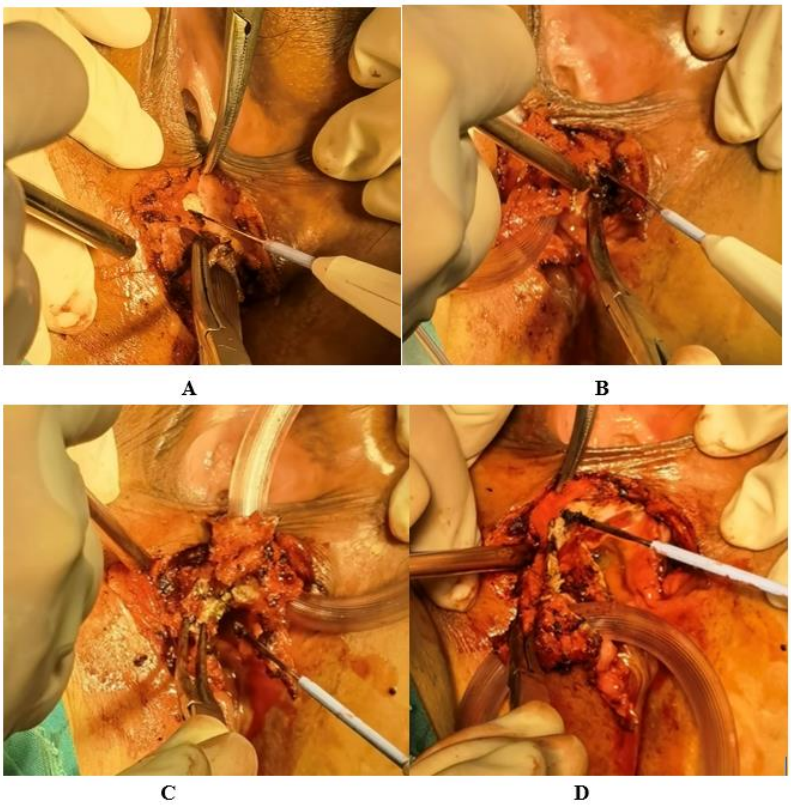
A **B** **C**

Figure 3: A) Re-examination before surgery. **B)** & **C)** View the plastic hose from above and below.



A **B**

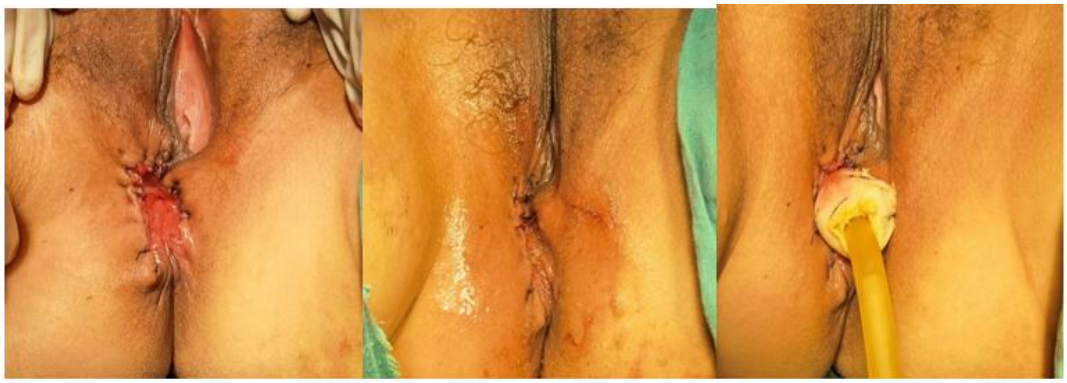
Figure 4: A) & **B)** Resecting the fistula from the left side and right side.



A **B**

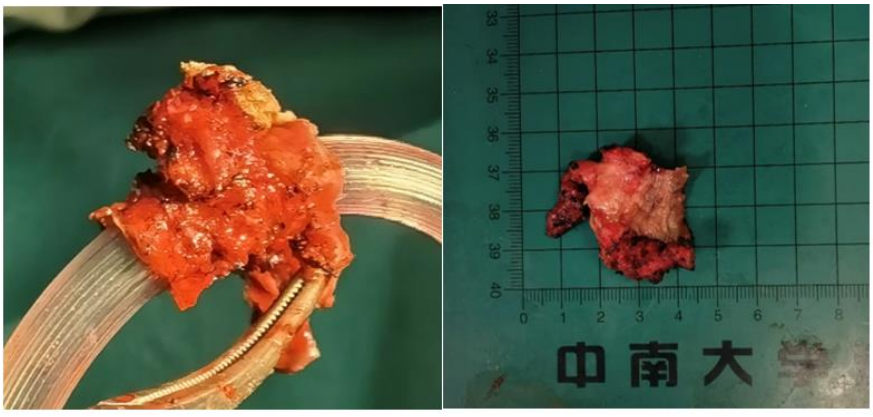
C **D**

Figure 5: A)-D) Resecting the fistula in the depths. It must be careful and meticulous to protect the sphincter.



A **B** **C**

Figure 6: A) & **B)** Showing the inside and the outside of the wound. **C)** Inserting the anal canal.



A **B**

Figure 7: A) We successfully resected the complete fistula. **B)** The length of the fistula is about 2.5 cm and the perimeter is nearly 2 cm.

Discussion

The previous reports had written down such cases like ectopic anus, double anus with total colon duplication, double gallbladder and its treatment, a didelphys uterus or having multiple compound deformities [1-5]. In our patient, duplication involved the anus only and no one had reported it before. In this case, there were three characteristics. Firstly, this disease was formatted with birth and progressed without human intervention. In other words, this was a congenital disease. Secondly, the patient has been suffering from this disease for 33 years. In an adult, this was a rare case to handle at this age. Last but not least, fortunately, the fistula did not involve in any muscle. So, the patient had an integral anal sphincter and a better prognosis of controlling stool excretion.

Patient Outcome

After several days of treatment in the hospital, the patient resumed anal exhaust and defecation. The wound closed to the anal heals well and had no feces or pus outflow. But it still needed to keep the wound relatively clean. So, we asked the patient to keep a sitz bath with low concentration potassium permanganate for 5-7 days after leaving the hospital.

Ethical Approval

Not applicable.

Consent

Not applicable.

Availability of Data and Material

The datasets used and/or analysed during the current study are available from the author on reasonable request.

Conflicts of Interest

None.

Funding

None.

REFERENCES

1. Bryndorf J, Madsen CM (1960) Ectopic anus in the female. *Acta Chir Scand* 118: 466-478. [Crossref]
2. Banu T, Chowdhury TK, Hoque M, Hannan MJ (2007) Congenital double anus with total colon duplication: a case report. *J Pediatr Surg* 42: E1-E2. [Crossref]
3. Yu W, Yuan H, Cheng S, Xing Y, Yan W (2016) A double gallbladder with a common bile duct stone treated by laparoscopy accompanied by choledochoscopy via the cystic duct: A case report. *Exp Ther Med* 12: 3521-3526. [Crossref]
4. Shi L, Lin X, Sha S, Yao L, Zhu X (2017) Delayed presentation of uterine rupture in a didelphys uterus misdiagnosed as appendicitis: a case report and review of the literature. *Arch Gynecol Obstet* 296: 1015-1016. [Crossref]
5. Stephens FD, Smith ED (1988) "Duplications and vesicointestinal fissure" In: Anorectal malformations in children: update 1988. *Birth Defects Orig Artic Ser* 24: 554-555.