

and faeces. The colostomy was closed on 28.10.1983. After this procedure he made a slow but satisfactory recovery, despite a burst abdomen which was resutured under general anaesthesia.

The patient was discharged on 22.11.1983: At the time of discharge he had full control of faeces and flatus. However, he had a narrow anal canal which required self dilatation. When reviewed in out patient department in September 1984, he had no complaints as regard defection and there was no stricture but he had a small incisional hernia of the abdominal wall.

Coment:

Anal sphincter injury is rare. Mostly it occurs during surgery of fistula in ano, haemorrhoidectomy, forceful anal dilatation and during drainage of perineal abscess. Gynaecological and obstetric injury is another cause of damage to the anal sphincter. Some cases follow accidental trauma especially if there is a fracture pelvis. The social and perhaps religious life of such an individual becomes a misery and he is condemned to live with it.

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The results of repair are improving as a result of better understanding of the problem and availability of effective antibiotic cover. A diversional colostomy is essential as without it, infection may result in failure of repair of the sphincter. The success rate of repair has been variously reported from 42% to 80%. In most of the cases decribed in the literature available to us, the sphincter has been injured at one site. In the case decribed, it was possible to achieve successful repair of the sphincter divided at two sites.

The usual cause of failure is a deficient blood supply and infection. Injury to the nerves of the area has been an other cause of failure specially in accidental trauma cases.

Reference:

1. Rob & Smith. Operative Surgery (Colon, Rectum and Anus) London. Butterworths & Co. 1977. P.245-248.

CASE REPORT

Repair of Anal Sphincter Divided at Two Sites.

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Abstract:

A case is presented where the anal sphincter divided at two sites has been repaired successfully by a single layer technique.

Key Words: Anal Sphincter Injury — Repair.

Introduction:

Anal Sphincter injury is rare. Successful repair is comparatively recent, and the technique and results of repairs are improving¹. A case is presented where successful repair has been achieved though the Sphincter was divided at two sites.

Case Report:

M.H. a 55 years old male presented in emergency on 10th September 1982, with history that he was operated upon by some quack for piles, a few days ago, resulting in incontinence of faeces, and dribbling of urine, through the operation wound.

Clinically his general condition was poor, he was very toxic and dehydrated. There was severe infection in the peri-anal region. After resuscitation, surgical debridement of the wound and complete diversional sigmoid colostomy and suprapubic cystostomy was carried out. Massive doses of antibiotics were given. The first debridement achieved partial clearance. Then a second debridement was carried out a week later on 14.9.1982.

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After this, he made a slow recovery. His urethral wound healed and after passage of Foley's catheter per urethrum, his suprapubic catheter was removed. The patient showed no anal sphincter tone at all. The Foley's catheter was removed and he started micturating normally. He was sent home with colostomy on 18.10.1982.

He was seen as an out-patient on 29.8.1983. with prolapse of the proximal end of the colostomy. On rectal examination, he had no tone or any evidence of intact anal sphincter. Amputation of prolapsing segment of colon was performed on 3.9.1983.

An exploration was carried out under general anaesthesia on 24.9.1983. to assess his anal sphincter injuries. After the excision of the scar tissue careful dissection identified the cut ends of the injured anal sphincter. The fibrous tissue surrounding the cut muscle was preserved for suturing purposes. Repair was carried out with number one Prolene² in one layer with figure of 8 sutures.

After two weeks of this procedure anal sphincter function was tested by:-

- (1) Pin Prick.
- (2) Asking the patient to grip the finger in the anal canal.
- (3) By ability to hold fluid inserted per anum and per colostomy.

The patient could hold the administered fluid and he could mimic defecation by pushing out the fluid per anum on command. He had full control of fluid, flatus