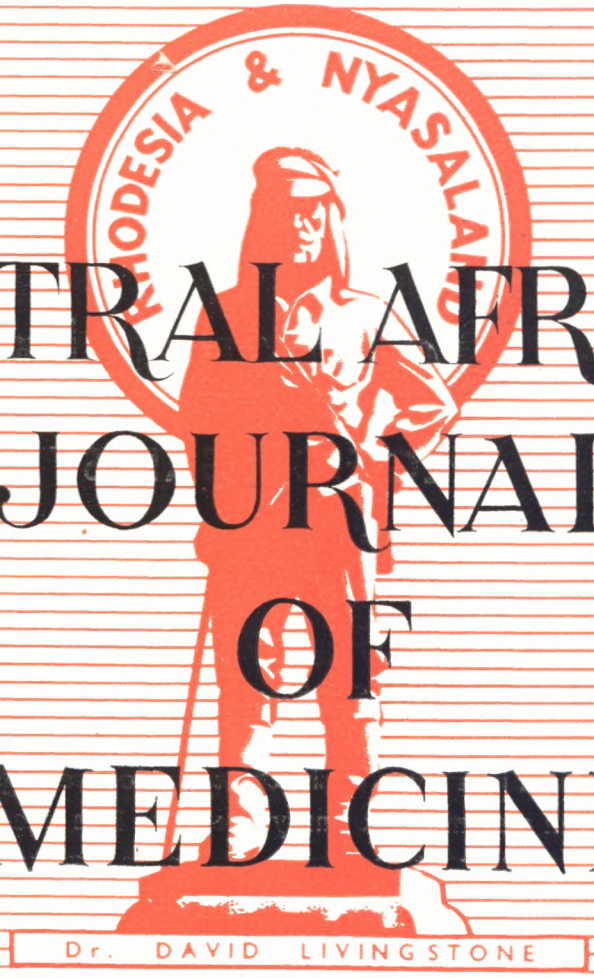
The CENTRAL AFRICAN JOURNAL OF MEDICINE



Vol. 2. No. 2. FEBRUARY, 1956

CONTENTS

PUBLISHED MONTHLY, ANNUAL SUBSCRIPTION £2 2s. 0d.
Registered at the General Post Office as a Newspaper.

A Case of Congenital Absence of the Anus

BY

R. T. MOSSOP. M.B., CH.B. (Cape Town).
Late Medical Officer, Fort Johnston, Nyasaland.

An African mother brought her four-day-old daughter to the district hospital, a distance of 65 miles, on foot over swollen rivers and rain-sodden tracks, with a history story that the child has passed nothing *per rectum* since birth.

The infant, which weighed 5 lbs. 1 ozs., had a considerably distended abdomen, through whose wall peristaltic movements were easily seen. The cord, which was filthy, was still attached.

Inspection of the perineum showed neither an anus nor an anal dimple, though there was slight bulging when the infant cried. Escaping from the vulva was a very small quantity of meconium which the mother had not previously observed. A finger could be pressed up between the ischial tuberosities. Examination of the child revealed no other abnormality.

As no X-ray apparatus was available, it was impossible to gauge accurately the depth of mesodermal tissue between the rectum and skin. However, the presence of a rectovaginal fistula and the bulging of the perineum suggested that the depth was not great.

Wangensteen, quoted by Aird,[1] states that where a rectovaginal fistula is present, operation should be delayed until the child is between four and eight years old. In this case, however, the fistula was small and signs of obstruction were present, so operation of some kind appeared to be essential.

After consultation with the mother, who refused any form of treatment which would leave her child with anything but an anus in the right place, it was decided to do this, if possible.

Under ethyl chloride and ether open anaesthesia, an incision was made along the raphe from half an inch behind the vulva to the coccyx. The mesodermal tissue was then divided in the midline immediately in front of the sacrum until the rectum was found at a depth of 2 cm. Bleeding was at no time a problem.

The rectum was then mobilised as much as possible, and was seen to end anteriorly at the posterior wall of the vagina. It was then stitched under slight tension to the skin. The excess skin incision was closed with catgut and the rectum opened. About six ounces of meconium were expelled under pressure, the abdomen deflating visibly.

After the operation the child was allowed to resume feeding as soon as it showed a desire to do so: the anus was bathed every two hours in a weak Dettol solution and dried: and the child received penicillin and antitetanus serum, mainly as a prophylactic against "cord tetanus," which is common in the district.

On the third day the sutures holding the rectum to skin had given way and the rectum was retracted. Nothing active was done about this, and by the tenth day there was a normal looking mucocutaneous junction, the skin was *clean and not excoriated. It was difficult to* distinguish the anus from that of a normal infant of the same age.

From the day after operation no further *meconium or faeces could be found in the vagina* or vulva, and the child was dirtying napkins infrequently and intermittently.

On the thirteenth day the mother could no longer be kept in hospital so that we might observe further progress, and she departed with her infant in order that she might resume the care of her crops.

Three months later the mother brought her baby in response to several messages through the post and *via* district commissioners, messengers and the like. The baby was in excellent condition and weighed just over nine pounds. *It was difficult to prove that there had been* anything wrong with the anus, but there was a suggestion of stenosis, so the mother was instructed and shown how to insert daily a lubricated finger into the anus. She departed happily after telling us that the child did not dirty her napkins any more frequently than the other babies had done. Moreover, the vulva had remained clean.

It would seem, perhaps more by luck than by anything else, that a sufficiency of anal sphincter muscle had been preserved during dissection and that division had occurred in the right place.

Discussion

Aird [1] states that the incidence of anomalies of the rectum and anus is of the order of one per 10,000 births. The majority of anomalies *fall into one of the three groups:—*

(a) Imperforate anus, where the cloacal membrane persists and the rectum is separated from the lumen of the anus by a double layer of epithelium.

(b) Congenital absence of the anus, where not even a dimple is present to indicate the site of the anus.

(c) Congenital absence of the rectum, where the colon ends blindly some distance above the perineum, and an anal dimple may or may not be present.

These three groups are often complicated by an internal fistula which opens from the gut into the vagina in females, and into the bladder or more commonly the membranous urethra in males.

The case described obviously falls into the group of absence of the anus, complicated by a fistula into the vagina.

Romanis and Mitchener [2] advise colostomy in such cases, though they state that no operation should be undertaken for three to six months unless obstruction occurs. On the other hand, Aird [1] holds that where possible a perineal anus should be established, even at a cost of deep dissection, for the mortality of perineal dissection is 25 per cent.; that of colostomy 50 per cent. However, he advises that no treatment should be given for four to eight years if there is a fistula.

In this case obstruction was present, despite the presence of a small fistula, and there was strong maternal objection to any opening other than by the perineal route. Relief of obstruction was essential, so a perineal anus was established with some trepidation, but with an excellent immediate result.

Most authorities consider that a repair of the rectovaginal fistula is necessary, but is often difficult and unsatisfactory. In this case the fistula was so small that obstructive signs were present and no attempt was made to close it. For three months after operation the fistula has given no indication of its presence and may well close on its own. If not, there will be minimal disability until the child reaches puberty and the organs are of such a size that closure will present relatively little difficulty.

In practice amongst primitive Africans surgery may often be the means not only of alleviating suffering and saving life, but by its very drama gain the confidence of the Native population. This confidence is essential if co-operation is to be expected in dealing with the less dramatic but more widespread and important endemic debilitating diseases. Therefore, whatever may be the main interests of a district medical officer, it is essential that he should attain some proficiency in surgery, for confidence is placed, especially amongst the primitive, in the person rather than in modern medicine itself. It is therefore all the more gratifying when, in contrast with many, such cases are brought early enough to hospital to be dealt with satisfactorily.

SUMMARY

A case of congenital absence of the anus, with rectovaginal fistula, is described. Treatment, consisting of the simplest surgery possible, gave extremely gratifying results.

Acknowledgment

I wish to thank Dr. D. M. Blair, O.B.E., Acting Secretary for Health in the Federation of Rhodesia and Nyasaland, for permission to publish this note.

REFERENCES

(1) AIRD (1949). *Companion in Surgical Studies.* Edinburgh: E. & S. Livingstone.

(2) ROMANIS & MITCHENER (1952). *The Science and Practice of Surgery.* London: J. & A. Churchill.