Rectal perforation after injection sclerotherapy for hemorrhoids: Case report

Injection sclerotherapy is a widely practised, effective, and generally safe method of treating first- and second-degree hemorrhoids. We describe possibly the first reported case of rectal perforation after injection sclerotherapy.

A 21-year-old man had symptoms of bleeding from hemorrhoids for 7 months for which he received injection sclerotherapy, using 5% phenol in almond oil from a private practitioner. Within the next 48 hours he developed pain in the perianal region, which increased on defecation, along with high-grade fever and vomiting. The perianal pain became progressively more severe over the next 5–6 days and from the 7th day onwards the patient also developed bleeding per rectum and foul-smelling discharge from the perianal area.

On general physical examination he was febrile, dehydrated, and had a pulse rate of 100/min. On local examination, there was blood at the anal opening and multiple pilonidal sinuses along the natal cleft which emitted a foul-smelling discharge. Digital rectal examination (DRE) revealed two irregular mucosal defects, one 3 cm × 3 cm at 9 o’clock position around 3 cm from the anal verge, and another 7 cm × 5 cm at 4 o’clock position, leading into the pararectal space around 3.5 cm from anal verge. On proctoscopy, the findings on DRE were confirmed.

Laboratory investigations showed hemoglobin 11.5 g/dL and WBC count 12 × 10^3/mL, with neutrophilia. Blood urea and blood sugar were within normal limits. X-ray of the soft tissue did not reveal any gas in the subcutaneous plane. An MRI of the pelvis (with gadolinium) revealed anorectal wall perforation at 5 o’clock position and a collection in the left ishiorectal fossa with an air–fluid level (Figure).
The patient was given intravenous antibiotics (ceftriaxone 1 g q 12 hourly and metronidazole 500 mg q 8 hourly). At surgery, about 25–30 ml of purulent fluid was drained from the pararectal space. Intraoperative examination revealed rectal ulceration (3 cm × 3 cm) at 9 o’clock and perforation of the left lateral rectal wall (7 cm × 5 cm) at 3 o’clock position, which extended into the left pararectal space. The sigmoid colon and rectum were copiously lavaged with antibiotic solution and a proximal defunctioning sigmoid colostomy was done. The associated pilonidal sinuses were laid open.

The postoperative course was uneventful. Clinical examination and distal cologram revealed that at 16 weeks post surgery, rectal injuries had completely healed. The colostomy was closed 5 months after the initial surgery.

Many different substances have been used for injection sclerotherapy but the most popular sclerosant is 5% phenol in almond oil. Retroperitoneal and subcutaneous abscesses, injection ulcers, necrotizing fasciitis, anal stricture, prostatic abscess and fistula, and superficial necrosis following sclerotherapy have been described previously. In the present case, the patient developed severe reaction to the sclerosant in the form of fever and local sepsis, which caused necrosis of the wall possibly due to impairment of vascularity. To the best of our knowledge, no similar complication has been described before.5

References


Correspondence to: Professor Lal, B-90, Swasthya Vihar, Delhi 110 092, India. Fax: 91 (11) 2323 5574. E-mail: drplal@vsnl.net, drplal@bol.net.in

Letters

Anubhav Vindal, Pawanindra Lal, Jagdish Chander, Vinod Kumar Ramteke Department of Surgery, Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India

Figure: Axial T2-weighted MR image showing an oblong cavity in the left ischiorectal fossa and pararectal tissues (asterisk) with an air–fluid level (arrow) extending anteriorly into the left peri-vesical space. A thin, fluid-filled tract (double arrow) can be seen leading anteriorly from a pilonidal sinus. R rectum; Bl urinary bladder; P pilonidal sinus