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Exploring the Thiersch Method in a Case of Partial Rectal Mucosal Prolapse: A Case Report

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ABSTRACT:

Rectal prolapse, involving protrusion of rectal mucosa or full-thickness rectal wall through the anal canal, significantly impairs patient quality of life. Partial rectal mucosal prolapse often presents with straining, discomfort, and visible anal mass, necessitating timely and effective intervention. A 60-year-old female presented with a 6-months history of mucosal prolapse through the anus, associated with mild pain, constipation, and straining during defecation. The case was diagnosed as partial rectal mucosal prolapse was diagnose. The patient underwent a Thiersch procedure a minimally invasive surgical technique involving subcutaneous anal encirclement using a Ethicon 1-0 (Non absorbable). Post-operatively, an integrative Ayurvedic regimen was administered, including *Panchavalkala Kwatha* for wound irrigation, *Yashtimadhu Ghrita* for aseptic dressing, and internal medications: *Kaishora Guggulu* (1 g, thrice daily before meals) and *Eranda Bhrishta Haritaki* (5 g at bedtime with warm water) to manage inflammation and constipation respectively. The post-operative course was uneventful. The patient showed significant symptomatic relief with no recurrence of prolapse or complications observed during regular follow-up. This case illustrates a successful outcome of the Thiersch procedure when complemented by Ayurvedic post-operative care. The integrative approach showed promise in enhancing wound healing, maintaining bowel regularity, and preventing recurrence in partial rectal mucosal prolapse.

KEYWORDS: *Guda Bhramsa,* Partial rectal mucosal prolapse, Thiersch Method.

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INTRODUCTION:

The term rectal prolapse encompasses a spectrum of disorders that result from intussusception or invagination of the rectal wall in a partial-thickness or full-thickness fashion, in varying degrees of protrusion to and through the anal sphincter complex. Many authors recognized that the underlying abnormality starts well above the pelvic floor, and described the importance of herniation of the pouch of Douglas[1]-[2] rather than a disorder of the physiology of the anal sphincter. An anatomic classification of the disorder provided a bit more clarity regarding the differing degrees of prolapse[3] Complete rectal prolapse is less common when compared with mucosal variety.[4] The precise cause of rectal prolapse is not fully understood, but certain factors seem to be implicated in its development. It is thought to commence as an intussusception of the rectum, which descends to protrude outside the anus. It usually occurs in persons at both extremes of life.[5] Medication-induced constipation in psychiatric patients and possible pelvic floor weakness in patients with previous pelvic surgery may be contributing factors to rectal prolapse. It is often associated with uterine prolapse in females. Symptoms include tenesmus (straining sensation), a sensation of mass protruding from the anus that may or may not spontaneously reduce, and a feeling of incomplete evacuation. Mucus discharge may accompany the protrusion. Patients also present with various functional complaints, from faecal incontinence (especially post-defecation) and diarrhoea to constipation and outlet obstruction.[6]Physical examinations with proctoscopy is a must and is essential to diagnose rectal prolapse and differentiate it from other prolapsing masses, such as cystocele, enterocele, or vaginal vault prolapse (seen in women). It is essential to note the descent of prolapse while straining or the Valsalva manoeuvre and the reducibility of the prolapsed mass.

Etiological Factor is atients to a weak pelvic floor, These include large birth weight of vaginally delivered babies, prior pelvic surgery, increased body mass index (BMI), chronic straining, chronic diarrhoea, chronic constipation, cystic fibrosis, neurologic diseases that lead to denervation of the pelvic floor (i.e., cauda equina syndrome, spinal cord lesions), connective tissue disorders (i.e., Marfan's syndrome, Ehlers–Danlos syndrome), dementia, and stroke).[7]

Several radiological investigations, such as defecating proctography, magnetic resonance defecography, or dynamic perineal ultrasound, could aid in prolapse diagnosis. There have been numerous methods of management for rectal prolapse. Conservative management, which may be digital repositioning, pelvic floor exercises, submucosal injection, or banding, is done for infants and children. However, surgery is the primary therapy for rectal prolapse, and different procedures have been described to treat this condition with their own limitations. Operations can be categorized as either abdominal or perineal approach. The surgical treatment of rectal prolapse involves several operative techniques to correct the prolapse and address associated issues. These can be respective, fixative, or a combination of both to achieve anatomical repositioning of the bowel and improved function of the anorectal complex.[8-9] This procedure applies to patients of various ages and is particularly favourable for those with significant comorbidities. The choice of management strategy depends on several factors, such as age, gender, incontinence, comorbidities, prior prolapse repairs, physiologic testing, surgeon's experience,

and, notably, preoperative constipation. Perineal approaches are more conservative, while abdominal approaches, which can be performed via laparotomy or laparoscopy, are more radical. These included Teflon, Marlex sling repair (Ripstein operation), or sutured posterior rectopexy [10]. The perineal approach is often preferred for elderly patients with severe comorbidities, while the abdominal approach is more suitable for younger patients with redundant sigmoid colon, constipation, or incontinence.

Acharya Sushruta has described *Gudabhramsa* under the heading of *Kshudra roga*.[11] Acharya Charaka has described *Gudabhramsa* in the chapter of *Vamana virechana vyapat* as a complication of *Samshodhana Chikitsa* by the name of *Vibhramsha*.[12] Acharya Vagbhatta described *Gudabhramsa* in the context of *Atisara Chikitsa*.[13] The exact aetiology has been explained by Acharya Sushruta for the 1st time. *Gudabhramsa* is a disease in which a patient becomes weak and lustreless and due to excessive straining during defecation or having diarrhoea, the internal part of *Guda* comes out. Its clinical features (such as *Atisara,* weak and wasted body of a person, and deficiency of ischiorectal fat) are very similar to rectal prolapse mentioned in conventional surgery.

Though, there are many surgical techniques available for this case, the Thiersch method remains relevant for elderly or comorbid patients due to its simplicity, minimal invasiveness, and lower recurrence rate. This case report presents a successful case of partial rectal mucosal prolapse managed by the Thiersch method with Ayurvedic post-operative care.

CASE REPORT:

A 60 year old female patient presented with a complaint of protrusion of mass from the anus associated with mild pain and constipation for the past 6 months. She was passing hard stools twice with straining. H/o She had three vaginal deliveries and There was no significant past history of familial, surgical, or allergic history. No any current medication for any systemic disease was found. Local examination has been given Table 1.(Figure – 1)

Investigations before Treatment:

All the routine pre-operative haematological, and biochemical investigations and complete urine routine were found within normal limits. Serology reports were negative.

THERAPEUTIC INTERVENTION:

Under spinal anaesthesia with all aseptic precautions, two small incisions (~1 cm) were made at the 6 and 12 o'clock positions in lithotomy posture. A subcutaneous tunnel was created circumferentially around the anal canal (superficial to the external sphincter). Ethicon 1-0 (Non absorbable). was passed through the tunnel, starting at one incision 12 o'clock and exiting at 6 o'clock and again entered from 6 o'clock and removed from 12 o'clock and tied at 12 o'clock with a surgical knot tight enough to prevent mucosal prolapse, yet loose enough to allow normal defecation and avoid ischemia or stenosis by confirming of passing index finger. (Figure-2)

Timeline of events have been summarized in Table 2.

Outcome and Follow Up:

No signs of recurrence have been noted during the follow up of 6 months. The patient continues to remain under regular follow-up.

Pathya-Apathya Ahara Vihara

Avoid sexual intercourse, physical exercise, riding bike or on camel etc animals, anger, and intake of heavy food for a period of one year after the complete healing of wound in *Bhagandhara*.[14] Even when the wound gets healed one should avoid things like *Ajirna* (indigestion), *Vyayama*(exercise), *Vyavaya*(Intercourse) along with these mental blemishes like *Harsha*(Happiness), *Krodha*(Anger), *Bhaya*(feeling). These have to be avoided till the stability is not attained.[15]

Table- 1: Local examination of Peri-anal region [Figure-1]

Site	Swelling in the right perianal region at 9 to 12 o'clock
Shape and size	Semicircular protrusion of through the anal verge. Length is 3 cm.
Colour	Reddish mucosa
Smell	Absent
Discharge	No active mucous discharge or bleeding noted
Surrounding areas	No inflammation and oedematous changes found.
Digital Rectal Examination	Irreducible Mucosal prolapse. Temperature and induration were absent with marked tenderness between 9 to 11 o'clock. The sphincter tone was found Relaxed.

Table 2: Timeline of the study

Date	**Therapeutic Intervention**
04/04/2025 (Pre-operative day)	First visit to Shalya Tantra OPD. Provisionally diagnosed as partial rectal mucosal prolapse. The patient was admitted to the IPD, and all routine pre-operative laboratory investigations along with pre-anaesthetic checkup were completed.
05/04/2025 (Operative day)	Under spinal anesthesia with all aseptic precautions, Thiersch Method was done using thread Ethicon 2-0. 1. Inj. Ceftriaxone (1 g) + Sulbactam 500 mg Intravenously, 12 hourly. 2. Inj. Ranitidine 2 ml Intravenously 12 hourly. 3. Inj Diclofenac 75 mg Intramuscularly 8 hourly.
06/04/2025 (1st Post-operative day)	Stopped 1,2,3 4. Tab Moxifloxacin 400 mg one tablet two times after food for five days. 5. Cap Rabekind DSR one tablet once before food for five days. 6. Tab Zerodol SP 1 tablet two times a day after food for five days. 7. Tab Becozyme C Forte 1 tablet at noon after food for 15 days. 8. *Panchavalkala Kwatha* for sitz bath once a day. 9. Wound irrigation with *Panchavalkala Kwatha* 10. Aseptic dressing with Yashtimadhu Ghrita. 11. *Kaishora Guggulu* (1 gm, thrice daily after meals). 12. *Eranda Bhrishta Haritaki* (5 g at bedtime with warm water).

11/04/2025 (6th Post-operative day)	Local, as well as systemic treatment continued. Continue Aseptic dressing with *Yashtimadhu Ghrita* at post-operative wound at 6 and 12 o'clock [Figure 2].
5/04/2025 (30th Post-operative day)	Wound healed completely[Figure 4]. All medicines were stopped. *Pathya-Apathya Ahara* and *Vihar* was advised to patient.

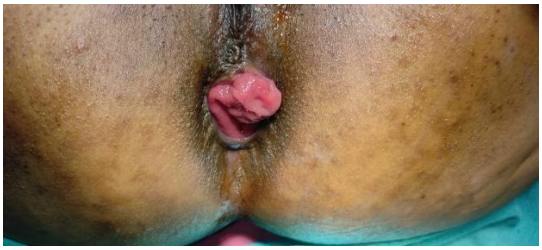

Figure 1 : Partial rectal prolapse BT

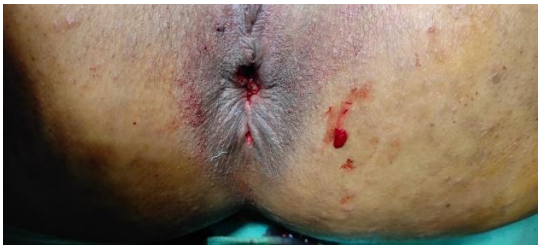

Figure 2: After Thiersch procedure

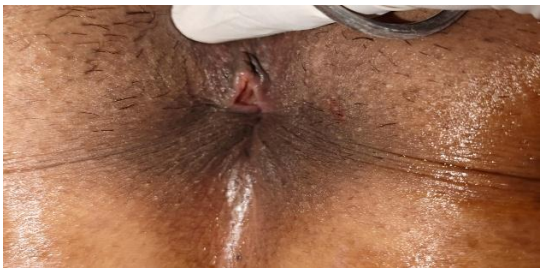

Figure 3 : Day seven Post operative

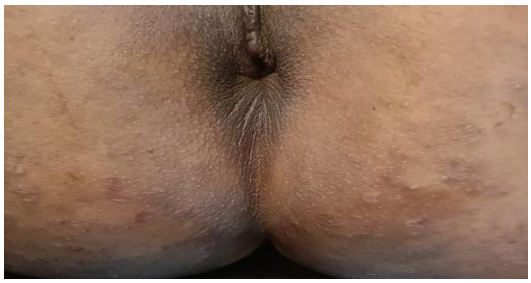

Figure 4: After complete recovery

DISCUSSION:

Various surgical procedures are proposed for rectal prolapse, from perineal approaches like simple Thiersch's operation to major abdominal operations such as rectopexy and rectosigmoidectomy. These need an abdominal approach, a well-equipped operation theatre, trained surgeons, etc

Ayurveda literatures have description of various diseases including detail description on anorectal disorders. *Gudabhramsha*, referred to as rectal prolapse in modern medicine, is explained in Ayurveda as the prolapse of the rectum caused by weakened anal sphincter muscles, aggravated Vata Dosha, and reduced strength of supportive structures. The causes of *Gudabhramsha* mentioned in Sushruta Samhita as *Pravahan* (straining to defecate), *Atisaar*(diarrhoea), *Ruksha-durbal-deha* (dry, person with loss of physical strength, weak). The clinical feature is —*Nirgacchati-gudam-vahi*" means circumferential descent out of rectum from anus.[16] The treatment strategy for *Gudabhramsha* in Ayurveda describes the *Snehana* (oleation), *Swedana* (fomentation), reduction of prolapse rectum, *Gophana* bandana (T-bandage*), Vatanulomaka* drugs, *Mushika taila*, *Changeri Ghritam*, *Anuvasana basti* etc.[17]Various treatment modalities practiced conventionally as conservative and surgical methods like Rectopexy etc. Although these procedures are effective but shows chances of recurrences, damage nearby structure, may causes complications, not easy availability of facility and procedure costly. To fill these

gaps Thiersch operation is in practice now and is popular treatment method .

When the conservative measures fail, this single operation is almost certain to succeed in partial prolapse. Patients of any age may be tried. This gives not only a mechanical support but also a chemical support by the fibrous deposits around the anal canal.[18].

After any surgery post operative care and life style modifications paly paramount importance. In this cse also after thiersch surgery patient treated with Ayurveda interventions. *Panchavalkala Kwatha* has anti-inflammatory, antibacterial, antiseptic, and antimicrobial properties that enhance wound healing after sitz bath. The chemical composition of *Panchavalkala Kwatha*, like tannins, phytosterols, and flavonoids, have anti-inflammatory properties; hence, they prevent the prolongation of the initial inflammatory phase, promote wound contraction by increasing collagen formation and ultimately improve wound healing.[19]

Yashtimadhu Ghritha was used further for external application owing to its *Vatahara, Pitta Shāmaka, Ropaka* (healing), Dāhashāmaka (soothing burns), and *Stambhaka* (astringent) actions. *Yashtimadhu* (Glycyrrhiza glabra L.) possesses *Madhura Rasa* (sweet taste), *Madhura Vipāka* (sweet post-digestive effect), *Śīta Vīrya* (cold potency), and *Vāta–Pitta Shāmaka* properties, which help in pacifying inflammation and supporting tissue regeneration. [20-21] It is also attributed with both *Vranaropana* (wound healing) properties. [22]

Kaishora Guggulu [23], plays a supportive role in *Vrana Chikitsa* due to its *Tikta-Kashaya Rasa, Laghu-Ruksha Guna, and Ushna Virya*, which help reduce *Kleda,* digest *Ama*, and clear *Srotorodh*a (channel obstruction). It acts as a *Rakta Shodhaka* and *Tridosha Shāmaka*, aiding in systemic detoxification and controlling inflammation associated with chronic wounds. Its *Madhura Vipāka* and *Rasāyana* effect support tissue regeneration and wound healing. [24]

Eranda Bhrishta Haritaki [25] (roasted Terminalia chebula in castor oil) possesses *Anulomana* (mild purgative) and *Āmapācana* (detoxifying) properties, which help eliminate accumulated metabolic waste from the *Koshtha (*GI tract) and *Shākhā* (peripheral tissues). By promoting digestion and regulating bowel movements, it aids in clearing *Āma*—the undigested toxic metabolites that impairs *Jatharagni* (digestive fire) and obstructs circulation. In context of *Vrana*, the systemic detoxifying action of *Eranda Bhrishta Haritaki* supports proper tissue perfusion and healing by improving *Srotoshodhana* (channel clearance) and *Dosha* balance, especially in chronic or non-healing wounds.

CONCLUSION:

The integration of Thiersch Method and post-operative Ayurveda treatment offers a promising therapeutic strategy, particularly for cases of partial rectal prolapse. This case underscores the effectiveness of Thiersch Method in treating anorectal disorders and enhancing patient outcomes.

Adverse Drug Reaction (ADR)

No ADR was noted and reported during and after the treatment course.

Consent of patient

Written informed consent was obtained from the patient for both the therapeutic intervention and publication of the case details and accompanying images. The patient was assured that his identity would be kept confidential and that all efforts would be made to ensure anonymity.

Conflict of interest: The author declares that there is no conflict of interest.

Guarantor*:* The corresponding author is the guarantor of this article and its contents.

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