Introduction

The STARR operation may represent an interesting progress in the surgical management of rectocele and internal mucosal prolapse.

Common complications are rectal bleeding, pelvic and anorectal pain, urgency and fecal incontinence. Uncommon complications are rectal perforation and pelvic sepsis, rectal diverticulum, anorectal stricture and rectovaginal fistula (4).

In this case report we propose sigmoid volvulus as another possible complication of STARR.

Case report

A 68-year-old woman presented with a 1-year history of chronic constipation with evacuation just once a week, obtained only by means of enemas and self endoanal digitations. The patient complained of a sensation of incomplete evacuation with painful effort and unsuccessful attempts. Medical history was positive for appendectomy, hysteroannesectomy, bilateral inguinal hernioplasty.

Physical examination revealed rectocele, without genital or urological prolapsed, and rectal mucosal prolapse. Defecography confirmed the diagnosis of rectocele and rectal mucosal prolapse without perineal descent (Fig. 1).

In this case report we propose sigmoid volvulus as another possible complication of STARR.

Discussion

The STARR operation may represent an interesting progress in the surgical management of rectocele and internal mucosal prolapse.
Encouraging short-term results have been reported after STARR with good to excellent outcome in 91% of patients (1). Other studies have shown persistence of symptoms in 44% of patients (2) and lack of improvement at mean follow-up of 20 months in 35% of patients (3). Common complications are rectal bleeding, pelvic and anorectal pain, urgency and fecal incontinence. Uncommon complications are rectal perforation and pelvic sepsis, rectal diverticulum, anorectal stenosis and rectovaginal fistula (4).

In this case report we propose sigmoid volvulus as another possible complication of STARR.

Sigmoid volvulus is the most common cause of strangu-lation of the colon and is also the cause for 1% to 7% of all intestinal obstructions in Western countries (5). The main predisposing factor to sigmoid volvulus is a long, redundant sigmoid colon with an elongated mesentery, which is prone to twisting on itself, especially if it is subjected to a contractile persistent stimulus.

Patients undergoing STARR are likely to complain
of urgency and frequent defecations, immediately after the procedure, due to a reduced rectal capacity. Urgency is present in 23% of patients undergoing STARR at a longer follow-up in a large multicentric series (6) due to a significantly decreased maximal tolerable volume (74 instead of 120 ml of air). Also, rectal relaxation related to the fecal mass causes the relaxation of the internal anal sphincter and the contraction of descending colon in order to activate defecation. So, the combination of postoperative urgency with a fecaloma in rectal ampulla may cause an iper-induction of descending and sigmoid colon contraction. We believe that this combination may cause a sigmoid volvulus in a patient with dolichosigma.

Conclusion
The development of a sigmoid volvulus post-STARR procedure is an unexpected event and surgeons should be aware of such complication because it might be much more frequent than believed.

References