Herbal enema: At the cost of colon

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Abstract

Various colonic side-effects of herbal enema have been reported in literature ranging from mild abdominal discomfort to self-limiting haemorrhagic colitis. It rarely requires blood transfusion or subtotal colectomy. We report a 57-year-old male patient developing severe ileo-colitis with persistent massive rectal bleeding immediately after herbal enema administration for the treatment of chronic constipation and was resistant to conservative management. Patient was managed successfully with emergency total laparoscopic colectomy. Post-operative recovery of the patient was excellent.

Key words: Emergency laparoscopic total colectomy, herbal enema, massive lower gastrointestinal bleed

INTRODUCTION

Enema administration has been a common practice worldwide for several centuries for the treatment of chronic constipation and for preparation of patient for a diagnostic test or a surgery.

The injurious effect of herbal enema is usually self-limiting. It seldom causes so prolonged lower gastrointestinal bleed that requires massive blood transfusion and rarely requires colectomy. There are few reports about the harmful effects of herbal enema in literature. Here we report an unusual complication of herbal enema in the form of severe ileo-colitis with persistent massive lower gastrointestinal bleed immediately after administration of enema for the treatment of chronic constipation. The bleeding was refractory to conservative treatment and was managed with emergency total laparoscopic colectomy.

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CASE REPORT

A 57-year-old male patient presented with persistent massive bleeding per rectum for one month that developed immediately after administration of herbal enema by a religious quack for the treatment of chronic constipation. He was admitted at some other hospital for the same complaint and was managed conservatively with oral glucocorticoid, 5-aminosalicylate preparation, metronidazole, entofoam (hydrocortisone acetate) and sucralfate enema. He had history of 48 units of blood transfusions during the course of conservative management to raise the haemoglobin above 8 mg/dl, but the condition did not improve and the patient was referred to our centre for further management.

On clinical examination, the patient was pale, had tachycardia (pulse, 136/min.) and hypotension (systolic blood pressure, 70 mmHg). Abdominal examination revealed normal findings. Rectal examination showed altered blood. His haemoglobin was 5.9 g/dl with haematocrit 20%. All other blood investigations were normal. Colonoscopy revealed extensive ulcerations and friability of entire colon, more on left colon and ileal intubation also showed multiple ulcerations [Figure 1]. CECT of abdomen showed distended small and large bowel with no air-fluid level.

We gave the patient a trial of conservative management because the condition was not permissible to withstand a major abdominal surgery. Conservative management did not work and once again patient developed massive lower gastrointestinal bleed bringing haemoglobin down to 4.9 g%. Patient was planned for emergency laparoscopic

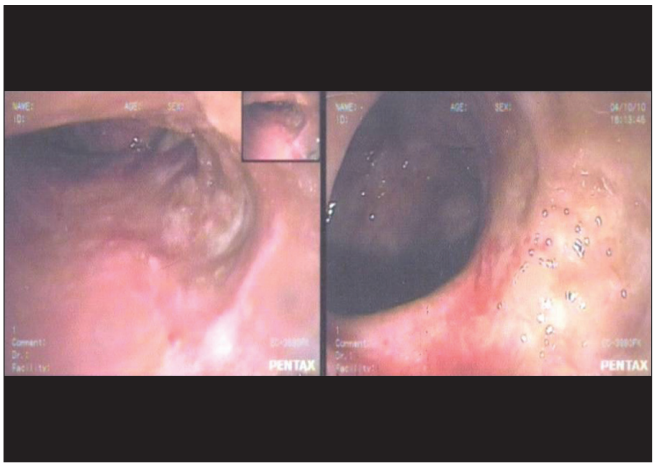

Figure 1: Endoscopic view: ulcerations and friability of colonic mucosa

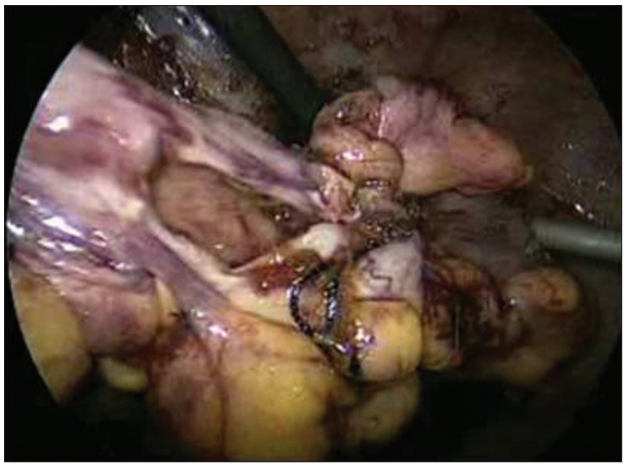

Figure 2: Intraoperative view showing an inadvertent perforation in edematous friable colon

total colectomy. On laparoscopy, there was evidence of mild ascites, thick oedematous inflamed and friable large bowel and distal 30 cm of ileum. Large bowel was very friable and developed 3 small inadvertent perforations by bowel holding grasper during dissection and manipulation of colon [Figure 2]. The perforations were managed by intracorporeal sutures to avoid peritoneal contamination. Total colon with distal inflamed ileum was resected laparoscopically. Hartmann procedure was done with end ileostomy at right spino-umbilical line. Specimen was retrieved by a small Pfannenstiel incision. The patient developed hyponatremia and paralytic ileus in early postoperative period that were managed conservatively. Oral liquids were started on postoperative day (POD) 3 and after that stoma started functioning. There was no wound infection. Drains were removed on POD5 and patient was discharged on POD 7 with advice of restoration of bowel continuity after 8-10 weeks.

DISCUSSION

Majority of the population of India is seemingly unaware of the potential hazards associated with herbal medications and of the limited knowledge and diagnostic skill of those who are prescribing such type of treatments.

Contrary to the widespread belief that because it is natural it is safe, herbal therapy probably carries major risks and produces more serious side-effects than any other form of alternative medicine.[1]

The common natural ingredients used in enemas are aloe, coffee, garlic and milk thistle. Other types of enemas include the ones made with mineral water, Epsom salt, glycerin, vinegar, bark of the marula tree, fruit of the Cucumis africanus, various wild herbs, industrial thinner, turpentine, undiluted dettol, ginger, pepper or soap.[2]

The injurious side-effects of herbal enema vary from mild abdominal discomfort and self-resolving haemorrhagic proctocolitis to severe colitis. Most of the time, colitis responds conservatively and rarely require blood transfusion and colectomy.

Herbal enema induced massive lower gastrointestinal bleed is a life threatening clinical condition usually refractory to conservative management as in our case. Nowadays, the indication for surgery is mainly limited to acute, uncontrollable, and recurrent forms of lower gastrointestinal bleed.[3] There are few studies in literature that address the feasibility of laparoscopic colectomy in emergency conditions. Marcello *et al,*[4] reported in their case-control study comparing laparoscopic total colectomy for acute colitis with a matched open colectomy group that laparoscopic total colectomy is feasible and leads to a faster recovery. The mortality rate from a subtotal colectomy in emergency setting is approximately 20% in most collected series,[5] because of the reluctance of surgeons to perform a subtotal colectomy early and defer it till desperate circumstances arise.[6] Early surgical intervention in such patients can improve the survival rate.

CONCLUSION

On the basis of surgical outcomes of this patient and literature support, we need for spreading awareness regarding the potentially disastrous adverse effects of herbal medications prescribed by quacks and advocate early intervention in such type of severe ileocolitis with massive rectal bleed.

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