Patient

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Rectal Prolapse

Rectal prolapse causes a lump to stick out of your back passage (anus) and this can become quite painful. Although the lump can pop in and out at first, later on it can stay out all the time, especially when you stand up. This can cause problems with daily activities that involve walking or standing for any length of time.

What causes rectal prolapse?

- Anything that increases the pressure inside your tummy (abdomen) can make you more likely to develop a rectal prolapse. This can include:
    - Constipation.
    - Diarrhoea.
    - Straining to pass urine due to a swollen prostate gland.
    - Pregnancy.
    - Persistent cough.

- Damage to the back passage (anus) or pelvis from previous surgery.
- Damage to the muscle on the floor of the pelvis.
- Infections of the bowel with certain types of microbes called parasites (such as amoebiasis and schistosomiasis).
- Diseases of the nervous system such as multiple sclerosis.
- Damage to the nerves from back surgery, a slipped disc, or an accident injuring the pelvic nerves.
- Mental health conditions associated with constipation, such as:
    - Depression.
    - Anxiety (as in irritable bowel syndrome).
    - A side-effect of medicines used to treat psychiatric disorders.

In children, rectal prolapse can occur in:

- Cystic fibrosis.
- Ehlers-Danlos syndrome.
- Hirschsprung's disease (a rare condition that can cause poo to become stuck in the bowel).
- Malnutrition (not having enough food, not eating the right food, or not being able to absorb the nourishment from food).
- Rectal polyps.

Click on the links for more information about the highlighted conditions.

Prolapse of the bladder or womb (uterus) doesn't cause rectal prolapse but is sometimes associated with it.

Who gets rectal prolapse?

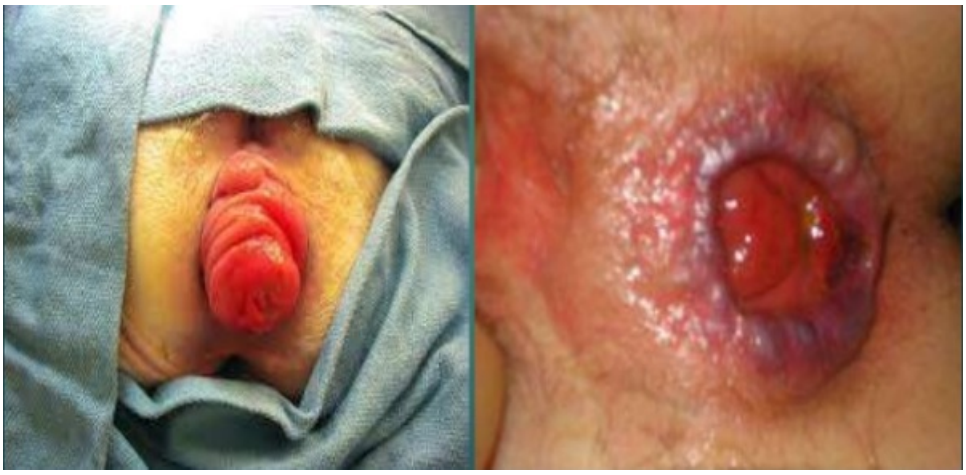
No-one knows how common rectal prolapse is because people often have it without reporting it to their doctor. However, it is known to happen most frequently in the elderly. Women seem to be more prone to it than men.

It is occasionally seen in children, especially from the ages of 1 to 3 years.

What are the symptoms of rectal prolapse?

A lump

- The first thing you will notice is a lump sticking out of your back passage (anus). In the early stages this will only appear after you've had a poo or strained to pass a motion. It tends to disappear when you stand up.
- Later on, you may notice the lump in other circumstances that involve straining, like coughing or sneezing.
- Eventually, the lump may be noticeable most of the time and interfere with day-to-day activities such as walking.
- You may have to push the lump back with your hand.
- A doctor examining the prolapse will see a lump sticking out which has concentric rings around it. An ulcer on the prolapse may also be seen.



Full rectal vs mucosal prolapse

Dr Hassan Mahmud, via SlideShare.net

Other symptoms

- You may notice pain, constipation and bleeding from the last part of your bowel (the rectum).
- The muscles around the anus (anal sphincter) may become weak, allowing a little bit of poo to escape (faecal incontinence). This can also happen with slime (mucus) produced by the bowel wall.

What else looks like rectal prolapse?

A prolapsed intussusception

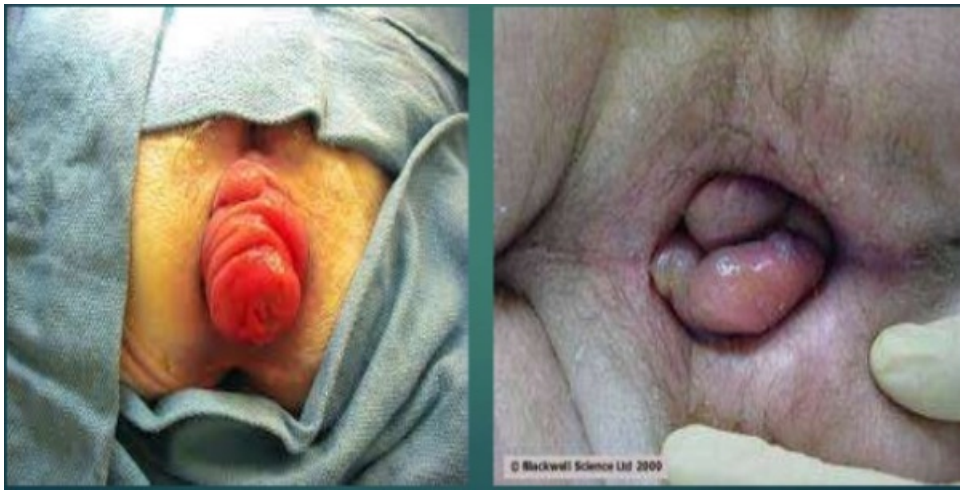
An intussusception occurs when a section of bowel folds into the next section, a bit like the way a telescope folds up. Sometimes the folded bowel pokes outside the back passage (anus) and looks like a rectal prolapse.

A rectal polyp

A rectal polyp is a thickening of the lining (mucosa) of the bowel that comes to resemble a finger-like structure growing out of the side wall of the gut. If it pokes outside the anus it can resemble a rectal prolapse.

A haemorrhoid

What we know as a pile is a large vein that usually develops from straining whilst going to the loo. This is yet another condition that can look like a rectal prolapse if it pokes outside the anus.



Difference between rectal prolapse and haemorrhoids

Dr Hassan Mahmud, via SlideShare.net

Do I need any tests for rectal prolapse?

- It's usually easy to tell if you have piles (haemorrhoids) rather than a rectal prolapse because a prolapse has concentric rings around the outside, whereas piles don't.
- You may need a barium enema (an X-ray exam of the lower bowel) to check that you haven't got any other bowel conditions. Instead of, or as well as this, you may be offered a colonoscopy (an examination in which a colonoscope - a thin flexible tube containing fibre-optic channels) is passed through your anus and into the lower part of your bowel (the colon).
- A proctosigmoidoscopy (an examination using a non-flexible scope) is used to check the rectum and anus for ulcers which sometimes occur with rectal prolapse.
- Anal physiology tests - these sound complicated but are basically ways of examining how your bowel works. They include X-ray pictures while your bowel is emptying (defecography), a test to check the pressure inside your bowel (manometry) and checks to test how well the muscles and nerves of the area are working. All this information is useful, especially if you are going to have surgical treatment.
- Other tests may be suggested, depending on what conditions the doctor wants to rule out. For example, a sample of your poo may need checking for infection or your child may need a sweat test to rule out cystic fibrosis.

What are the treatment options for rectal prolapse?

Treatment without surgery

- A prolapse which is small and/or has only recently occurred can sometimes be pushed back using pressure from your hand. If doing this is painful, a doctor may be required to do this after giving you a sedative and a local anaesthetic injection to numb the area.
- Make sure you sort out any underlying cause such as constipation or diarrhoea.
- If the prolapse cannot be pushed back you will need the attention of a surgeon.
- A partial prolapse (in which it's only the lining of the bowel that pops out) can usually be treated without surgery although sometimes the extra tissue needs to be trimmed off.
- In children, the prolapse can usually be gently pushed back using a lubricant gel. You need to make sure your child has a high-fibre diet and doesn't strain when they go to the loo. Sometimes a laxative is required. Very occasionally an injection that shrinks tissue (a sclerosant) has to be given.
- Most elderly people can cope by pushing the prolapse back themselves. However, sometimes a rubber ring is inserted under the skin to keep the prolapse in place. This is not very successful as it is often too tight (causing constipation) or too loose (causing the prolapse to poke out again).

Surgical treatment

Surgery for adults

- If your prolapse can't be pushed back and the blood supply has been cut off you will need emergency surgery. This involves removing the prolapse and part of the lower bowel (a rectosigmoidectomy).
- A prolapse involving just the lining (mucosa) of the bowel is treated by removing the excess mucosa. This is basically identical to surgery for a pile (haemorrhoidectomy). Staples are sometimes used instead of conventional cutting with a scalpel.
- Abdominal surgery involving opening the tummy. The basic procedure is called a rectopexy, which involves placing the lower part of the bowel (the rectum) back into its original position and fixing it so it doesn't slip down again. Various methods are used to prevent slippage, including sutures, staples, slings and shortening the stretched bowel. Surgeons are starting to use a laparoscope - a thin telescope with a light source - for some of these procedures. The instrument is passed through a small hole in the tummy, resulting in a smaller scar than you would get with conventional surgery.
- Perineal procedures - these involve surgery in the area of the perineum which is located between the anus and testicles in men or the anus and lower part of the vagina in women. Variations include:
    - Circling the anus with wire (Thiersch's wiring procedure).
    - Stripping some of the lining of the bowel off the prolapse, bunching up the bowel muscles with stitches, then replacing the lining (Delorme's mucosal sleeve resection).

Surgery for children

- This is usually reserved for children aged under 4 years who have failed to respond to non-surgical treatment for more than a year.
- Surgery may also be used where the prolapse keeps coming back, becomes painful or where ulcers or bleeding develop.
- Lots of different methods are used including:
    - Injections to cause scarring around the rectum.
    - Insertion of a sling to support the rectum.
    - Use of mesh gauze to pack around the rectum and the use of a hot probe called a cautery.
    - Opening the tummy (abdomen) to reposition the rectum.
    - Placing a suture inside the rectum so that scar tissue sticks it to the tail bone (the sacrum).

- As with adult surgery, some of these techniques are now being done through a laparoscope.

What is the best treatment for me?

Studies suggest that there is no difference in success rate whichever surgical procedure is used. Your surgeon will discuss the best option, taking on board your age, general health, previous experience with anaesthetics and how long you have had your prolapse. In general, young fit people are better off having a procedure through the tummy (abdomen). Older people may be more suited to perineal operations which can be done under local anaesthetic. There's more of a chance of the prolapse coming back but less risk to your health if you're a bit frail.

What are the complications of rectal prolapse?

Complications include:

- Ulcers in the lining (mucosa) of the lower part of the bowel (the rectum).
- Death of tissue (necrosis) of the wall of the rectum.
- Bleeding and breakdown (dehiscence) of tissue where two bits of bowel have been stitched together. These are the most common complications after surgery.

What is the outlook for rectal surgery?

The outlook (prognosis) will depend on your age, on whether you have any untreatable causes for the prolapse and on the state of your general health.

About 1 in 10 children who have a rectal prolapse will continue to have it when they grow up, especially if they are aged over 4 years when they first develop it.

Further reading & references

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