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Case Report Open Access

Rectal Prolapse due to Adenomatous Polyp: Case Report

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Abstract

Rectal prolapse represents full thickness protrusion of the rectum through the anal sphincter. Rarely, the prolapsed portion of the rectum can become neoplastic. The exact incidence of rectal prolapse although unknown, it is a rather rare entity. We hereby report a case of a rectal prolapse with neoplastic change. The present study report the case of a 58-year-old woman, without previous major diseases, diagnosed with a rectal prolapse. Eight months later she attended with evident prolapse towards the posterior quadrant of the anal margin with a polypoid lesion of approximately 5 cm × 5 cm. An altemeier's rectosigmoidectomy is executed. The histopathologic study reports a tubulovillous adenoma with high grade dysplasia.

Keywords: Rectal prolapse; Polypoid lesion; Adenoma

Introduction

Rectal prolapse is defined as the partial or total externalization through the anal orifice. Considering the partial prolapse the externalization of the mucosa and the total prolapse when all layers of the rectal wall are protruded, more rarely the rectum can be invaginated on itself, circumstance in which is not externalized and is known as internal prolapse. It often occurs in women over 50 years. Its causes are still unknown, although there are some risk factors like female gender, multiparity and a history of chronic constipation or serious evacuatory straining; generally associated to incontinence and bowel dysfunction.

The rectal prolapse may often be confused with haemorrhoidal prolapse, but invagination of rectal wall caused by tumours rarely appears through the anus [1-4]. A polyp is an elevation of the intestinal wall formed by any tissue whether mucosal, sub mucosal or of an even deeper origin; it can be neoplastic, reagent or congenital [5]. A case is presented with an initial diagnosis of prolapsed rectal polyp causing total protrusion of the rectum; evidenced by intraoperative ultrasonography (IOUS).

Case Report

A 58-year-old woman without previous major diseases starts suffering from evacuatory straining, occasional rectal bleeding and mass sensation 1 year prior to attending to a local ambulatory center. The patient is diagnosed with a rectal prolapse and started receiving medical treatment with signs of partial recovery.

Eight months later, she attends to the emergency department of the Hospital Universitario de Caracas with abdominal pain, growth of the rectal mass, rectal bleeding, and proctalgia so she is evaluated by the gastroenterology department and later referred to coloproctology department. The physical examination showed a soft, depressible, and painless abdomen with no signs of peritoneal irritation.

The proctological examination in the sims position showed evident prolapse towards the posterior quadrant of the anal margin with a polypoid lesion of approximately 5 cm × 5 cm, irregular surface, with necrotic areas and fetid seropurulent secretion (Figure 1).

Figure 1: Prolapsed rectal polyp.

The digital palpation showed sphincter with mild hypotonia. A pediculated, no reducible tumorous lesion was felt. The patient is brought to the operating table for a transanal resection of the lesion and biopsy. After the anaesthesia is applied, the rectal wall in relation to the polyp protruded though the anus, presenting as a total rectal prolapse (Figure 2).

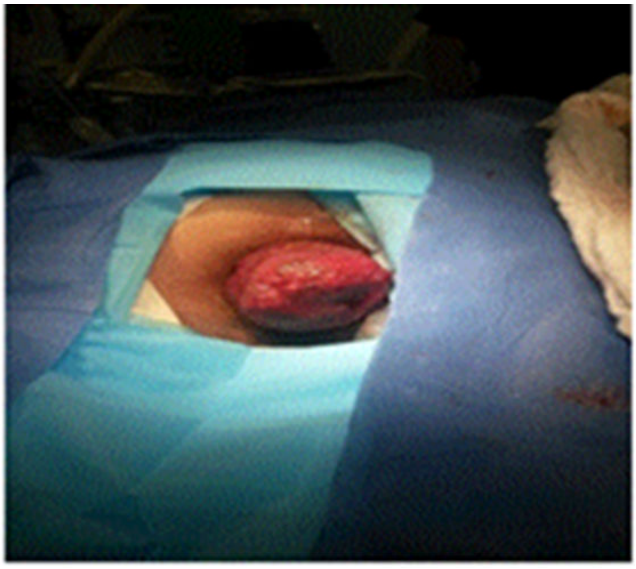

Figure 2: After the anaesthesia is applied, the rectal wall in relation to the polyp protruded though the anus.

An Altemeier's rectosigmoidectomy is executed without complications and the patient is released after 48 hours, with satisfactory evolution. The histopathologic study reports a tubulovillous adenoma with high grade dysplasia, exulcerated, with free resection margins (Figures 3 and 4).

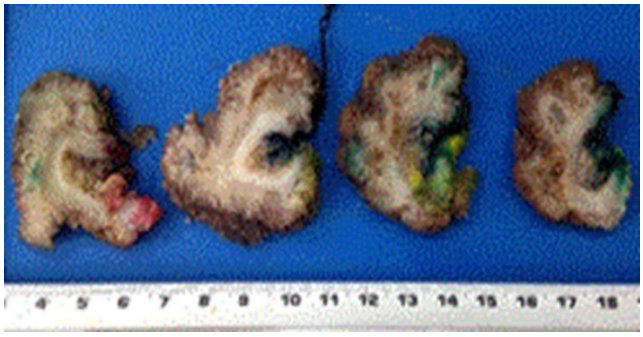

Figure 3: Macroscopic appearance of the polypoid lesion on the serial sections (resection margins are inked).

Discussion

The complete rectal prolapse is a multifactorial pathology, with a common clinical manifestation that corresponds to the exteriorization of the rectum and part of the sigmoid colon through the anus [1,2].

The different surgical techniques described for its treatment include abdominal and perineal approaches, with the best option depending on the patient because of the many aspects to be considered; according to the latest cochrane evidence.

The term "polyp" is used to describe any abnormal growth of tissue projecting from a mucous membrane. There are different forms to describe or classify these elevated lesions. Polyps can vary in size, shape and behaviour. They can also be single or multiple. They can be congenital or acquired, symptomatic or asymptomatic, benign or malignant, pedunculated or sessile [5,6].

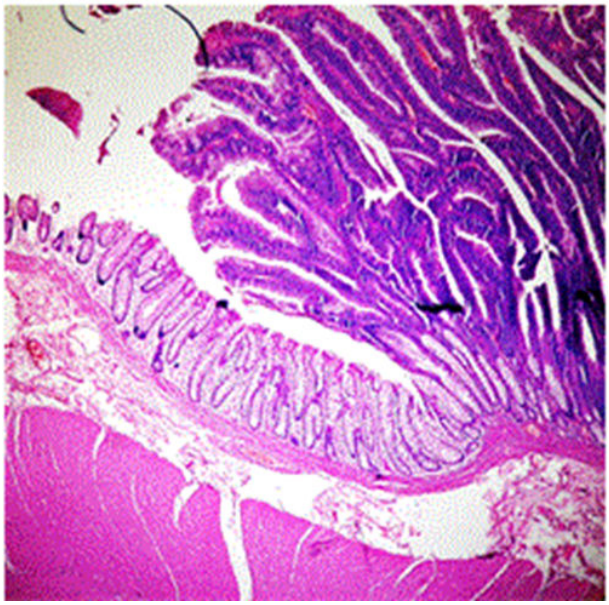

Figure 4: Histological section stained with hematoxylin eosin. Left: normal rectal mucosa with linear tubular glands. Right: arquitectural distortion with villous projections arising from mucosal surface lined by dysplastic epithelium (villous adenoma).

The histological diagnosis of polyps in the colon and rectum determines the surgical proper conduct with each patient. The behaviour treating a hyperplasic polyp should be different from treating a villous adenoma with high grade dysplasia. Likewise, the clinical characteristics of a juvenile polyp are very different than those of a cloacogenic one.

The risk of an adenoma to become malignant depends on its size, degree of dysplasia, and type. Adenomas with high grade dysplasia have a risk of 27%, higher than low grade ones which is only 5% in 15 years.

In respect of this particular case, a rectosigmoidectomy was performed thus ending the rectal prolapse and satisfactory resection of the polyp showing free margins. No other lesions were evidenced. However, the risk of recurrence of adenomas has been discussed in numerous studies, and despite the conflict, it has become clear that adenomatous polyps with high grade dysplasia have a greater chance of reoccur in a metachronous way with diverse grades of dysplasia or become cancer, so the patient is kept in colonoscopy control and surveillance over the next 5 years.

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