Internal rectal prolapse and solitary rectal ulcer

Internal rectal prolapse and solitary rectal ulcer syndrome

Internal rectal prolapse, or intussusception, refers to the invagination of the rectal tube during defecation. The prolapse descends towards the anal canal, where it can act as a blockage to defecation; a condition referred to as obstructed defecation. The patient describes the normal desire to defecate but an inability to satisfactorily evacuate the rectum, having to resort to excessive straining and sometimes digitation. Incomplete evacuation leads to a sensation of tenesmus, requiring repeated returns to the toilet. Intussusception is often accompanied by other structural abnormalities of the rectum, including rectocele and enterocele, which can further add to evacuatory di ffi culty (Figure 79.8). Treatment of internal rectal prolapse is indicated if it can be demonstrated on proctography and correlates with the patient's symptoms of obstructed defecation. Surgical options olapse are the same as those for for treating internal rectal pr external rectal prolapse, namely internal Delorme's procedure (perineal approach) or laparoscopic ventral mesh rectopexy (LVMR) (abdominal approach). Solitary rectal ulcer syndrome (SRUS) may also be another associated manifestation of obstructed defecation syndrome. Classically , SRUS takes the form of an ulcer on the anterior wall of the rectum, situated 6–8 /uni00A0 cm from the anal ver this form, it can be mistaken for rectal carcinoma or inflam matory bowel disease, particularly Crohn's disease. It may heal, leaving a polypoid appearance. Proctographic studies may indicate accompanying rectal intussusception or anterior rectal wall prolapse. Histology will confirm the diagnosis. The condition is di ffi cult to treat. Symptomatic relief from bleeding and discharge may sometimes be achieved by controlling any associated straining with re-coordination of defecation using biofeedback therapy . Transanal stapled resection of the intus susception (STARR procedure) or resuspension of the rectum by abdominal rectopexy may be beneficial, but the results are not as good as for internal or external rectal prolapse. In rare cases, rectal excision may be required with or without stoma.

Figure 79.8 Defecating proctogram with selected images from left to right showing normal pelvic /f_l oor position at rest with development of a small anterior rectocele on evacuation (thick arrow) and a rectoanal intussusception entering the anal canal (thin arrow) (courtesy of Dr Damian Tolan, St James's Hospital, Leeds, UK).

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