# Rectal prolapse

## Introduction

Rectal prolapse occurs when a mucosal or full-thickness layer of rectal tissue protrudes through the anal orifice. There can be complications if it is not treated promptly and properly.

Rectal prolapse is a relatively rare condition but more common in adults than children. Most cases are due to underlying conditions causing chronic straining with defecation & constipation. In children, it is usually seen as a complication of acute diarrhoea or worm infestation.

Rectal prolapse results in local symptoms (eg, pain, bleeding, and seepage), bowel dysfunction (eg, constipation, incontinence), and a diminished and disabled quality of life.

## Target users

* Doctors
* Nurses

## Target area of use

* Outpatient
* Ward

## Key areas of focus/ new additions/changes

This guideline primarily describes the diagnosis of rectal prolapse as well as the immediate medical management.

## Limitations

Adults with rectal prolapse should be referred to the surgeons as soon as possible. Children with worms or recent diarrhoea may be managed medically if the prolapse is reducible and doesn’t recur.

## Presenting symptoms and signs

The patient or their caregiver will complain of a mass protruding through the anus. Pain may be variable and sometimes may present with rectal bleeding. History may also include constipation or faecal incontinence, abdominal discomfort, incomplete bowel evacuation, and mucus and/or stool discharge associated with altered bowel habits. Straining to initiate or complete defecation, incomplete evacuation, and a history of digital manoeuvres to aid with defecation can occur as the prolapse progresses.

Factors that increase the risk of rectal procidentia include:

* Age over 40 years
* Female gender
* Multiparity
* Vaginal delivery
* Prior pelvic surgery
* Chronic straining
* Chronic diarrhoea
* Chronic constipation
* Cystic fibrosis
* Dementia
* Stroke
* Pelvic floor dysfunction (eg, paradoxical puborectalis contraction, nonrelaxing puborectalis muscle, abnormal perineal descent)
* Pelvic floor anatomic defects (eg, rectocoele, cystocoele, enterocoele, deep cul-de-sac)

## Examination findings

The diagnosis is typically made by the clinical evaluation. The most common sign is a full-thickness protrusion of the rectum, which may be intermittent. The prolapse may be best identified with the patient in the squatting position or even sitting on the commode. Rectal bleeding may be seen or a solitary rectal ulcer. There is usually a decreased anal sphincteric tone.

The patient may give a history of a recent diarrhoeal illness or itching anus.

## Differential diagnosis

* **Prolapsed internal haemorrhoids**: Internal haemorrhoids are swollen and/or inflamed veins present in the left lateral, right posterior, and right anterior walls of the anal canal. Grade IV haemorrhoids are prolapsed and cannot be reduced. The clinical features that distinguish rectal prolapse from prolapsed internal haemorrhoids include the presence of circumferential rings of mucosa (stacked coins) and a full-thickness protrusion with rectal prolapse (Prolapsing haemorrhoids result in linear folds.
* **Occult rectal prolapse (intussusception)**. An occult rectal prolapse involves intussusception, a "telescoping" of the bowel on itself internally, without protruding through the anal verge and is not a true rectal prolapse.
* **Rectal mucosal prolapse.** A small amount of rectal mucosa can protrude with straining that does not progress to full-thickness prolapse.
* **Solitary rectal ulcer**. This is an uncommon rectal disorder characterized by one or more mucosal ulcers or a polyp-like mass in the rectum. Patients present with bleeding, passage of mucus, straining during defecation, and a sense of incomplete evacuation.

## Investigations

Evaluation depends on the underlying disorder.

Laboratory test such as FBC may be necessary to exclude anaemia.

Barium enema or colonoscopy should be done for all adults to rule out malignancies.

## Management

Medical management is offered to minimize symptoms prior to a surgical repair, for those with comorbid illnesses that preclude a surgical repair, and for those who refuse a surgical repair. Medical management strategies are determined by the patient's symptoms, degree of prolapse, and the magnitude of the adverse effect on the patient's quality of life.

Initial medical management for all patients includes ensuring adequate fluid and fibre intake. High-fibre foods, fibre supplement (total 25 to 30 grams per day), and 1 to 2 litres per day of water and other fluids are used to regulate bowel movements and attempt to control seepage and/or constipation.

Enemas and suppositories may be required for patients with severe constipation and difficulty evacuating the colon.

Pelvic floor muscle exercises (eg, Kegel) may result in symptom improvement for women with pelvic organ prolapse in women. However, there are no data that suggest that exercises can effectively treat rectal prolapse.

If the condition is a new problem and has been present for no more than a few days, then you should be able to gently return the anus to its normal place with a gloved finger. If there is a history of diarrhoea or constipation then treat accordingly. The presence of itchy anus should be treated as per helminth infestation.

**If the condition has been recurrent, longstanding or the anus cannot be reduced, then consider referring to the EFSTH surgical unit.**

Note: In adults medical treatment of rectal prolapse is essentially surgical; no specific medical treatment is available. Children, however, can usually be treated non-surgically, by managing the underlying condition.

**Refer urgently to a general surgeon if any of the following is seen (Danger signs);**

* Irreducible prolapse
* Presence of gangrene or rupture of the rectal mucosa
* Anal incontinence

## Key Issues for Nursing care

* Recognize quickly the danger signs and refer to the doctor.
* Counsel the patient on the risk factors, sitz baths and how to keep a good anal hygiene.

## References

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