

## Severe anemia by rectal prolapse

R. González Soler, E. Castro Ortiz, A. González Ramírez and L. López Rosés

*Department of Gastroenterology. Hospital Xeral-Calde de Lugo. Spain*

### CASE REPORT

A 57 year old woman, with no known allergies, a history of excessive alcohol consumption and a previous diagnosis of compensated alcoholic cirrhosis of the liver, was admitted because of intermittent rectal bleeding and severe anaemia (Hb: 5 gr/dl). Physical examination showed a large rectal prolapse (Fig 1). After reducing the prolapse, a colonoscopy was performed and no other abnormalities were found. We also performed an anal endosonography that showed sphincter changes secondary to longstanding complete rectal prolapse, without disruption at any level. A surgical treatment was decided and it consisted in rectal wall section 1.5 cm. above the dentate line, opening of the anterior pelvic peritoneum and circumferential section of the meso with ligature and haemostatic suture. After separating the vaginal wall, the redundant peritoneum was excised and was fixed to the colon. Furthermore, a four sutures levator muscle anterior plasty and a manual coloanal anastomosis were performed.



Fig. 1. Large complete rectal prolapse.

### DISCUSSION

Rectal prolapse affects patients in both extremes of life, and women represent between 80 and 90 % of total cases (1). It consists of a total intussusception of the rectum (2) and it is called complete when all layers of the rectal wall protrude outside the anus. The prolapse is called mucous when only the mucous layer protrudes and it is called internal if intussusception doesn't go beyond the anal canal (1). The exact pathophysiology of this entity is unknown, but weakness of the pelvic floor and mobile rectum are usually present. Conditions that may be involved in the pathogenesis of rectal prolapse are constipation, obstetric traumas, hysterectomy, previous anorectal surgery, spina bifida and operations or traumas to the spine. The prolapse may occur as an isolated process or together with other pelvic floor problems, such as rectocele, enterocele, cystocele and uterine or vaginal prolapse (3). The most common clinical manifestation is the protrusion of the rectum through the anus, followed by passage of blood and mucus. Rectal prolapse may be associated with the rectal ulcer syndrome and frequently it is accompanied by incontinence and constipation (4-6). At exploration, the rectum is often oedematous and with small ulcers. The diagnosis is made on physical examination. Other diagnostic tests, like defaecography, anal endosonography or anal manometry, have limited utility for patient management, but are useful in studying the pathophysiology of the disorder. Complete rectal prolapse treatment is surgical, by transabdominal or perineal approach, the latter being preferred in elderly patients with comorbidities. In recent years, laparoscopic approach is gaining importance as a minimally invasive surgery.

## REFERENCES

1. Heine JA, Wong WD. Rectal prolapse. En: Mazier WP, Levien DH, Luchtefeld MA, Senagore AJ, editors. *Surgery of the colon, rectum, and anus*. Philadelphia: WB Saunders; 1995. p. 515.
2. Jacobs LK, Lin YJ, Orkin BA. The best operation for rectal prolapse. *Surg Clin North Am*. 1997; 77: 49-70.
3. Bruch HP, Herold A, Schiedeck T, Schwandner O. Laparoscopic surgery for rectal prolapse and outlet obstruction. *Dis Colon Rectum*. 1999; 42: 1189-95.
4. Kairaluoma MV, Kellokumpu IH. Epidemiologic aspects of complete rectal prolapse. *Scand J Surg* 2005; 94: 207-10.
5. Poen AC, de BM, Felt-Bersma RJ, et al. Laparoscopic rectopexy for complete rectal prolapse. Clinical outcome and anorectal function tests. *Surg Endosc* 1996; 10: 904-8.
6. Madoff RD, Mellgren A. One hundred years of rectal prolapse surgery. *Dis Colon Rectum* 1999; 42: 441-50.