RECTAL ULCER

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29 years old woman.
Christipation that started after delivery 18 months ago.
Abdominal pain.
Rectal tenesmus.
Episodes of incontinence for stools.
Defecation with mucus and massive bleeding.
Anal digitation for defecation.

Underwent two colonoscopies - Ulcer 9 cm distance from the anus.

Biopsy: SRUS.
• **Manometry anorectal** – Normal. No anismus.

• **Video‐proctography**- Intussusception without prolapse, with partial defecation.

• **EAUS and PUS** - No emptying of gel. Suspected intussusception??
• Abdominal pain.
• Rectal bleeding.

• Treatment: Colifoam enemas.
• Improvement of symptoms.

• Recommendation: Sigmoidoscopy.

• Macroscopy: polyp? Neoplasia?

• Microscopy: Tubular adenoma low grade dysplasia.
Recommendation: colonoscopic local excision of the finding.

- No success in the “excisional” biopsy.
- Pathology: SRUS.
- Recommendation: Rafassal enemas.
• 11/2010: Recurrent colonoscopy at the distal small bowel: Only the “tumor” finding in the rectum.

• Biopsies:
  1. Four fragments of normal ileal mucosa.
  2. Two fragments of normal colonic mucosa.
  3. Multiple fragments of rectal mucosa showing histological feature of solitary rectal ulcer.
• **Anorectal manometry** – Rest pressure: 45 mm Hg, squeeze 165 mm Hg. Reflexes, sensitivity and capacity normal. **There is anismus. No balloon expulsion.**

• **DPUS and EAUS** - Intact sphincters, **lack of sphincters relaxation during attempted evacuation.** Anismus. Mucosal intussusception during attempted evacuation. Suspected complete prolapse of the rectum.

**Recommendation:** Biofeedback, bulking agent.
• Rectal bleeding.
• Complete rectal prolapse.
• Abdominal operation...

• Perineal approach...

• Conservative treatment...
Case 2

- 26 years old woman
- Three years ago diagnosed proctitis.
- Underwent left lateral sphincterotomy d/t anal fissure.
- Rectal bleeding for 3 years.
- Constipation and diarrhea alternately.
- Anal itching.
• Normal colonoscopy a year ago.
• In the last 6 months, rectal bleeding in shorter periods.
• Mucus secretions.
• Abdominal pain.
• Constipation.

• New colonoscopy: Anorectal ring ulcerated polyps. Normal mucosa between them.
• Histology: Not enough for diagnosis.

• New colonoscopy: Rectal ulcer.
• Histology: suspect SRUS.

• Rectoscopy: Rectal mass, posterior rectal wall, at 7-8 cm from de anus.

• Normal gastroscopy.

• TRUS: Rectal ulcerated mass, not penetrate beyond the Muscularis propria.
• TEM_ Mass, posterior rectal wall, 5 cm from the anal verge. An other mass, 7 cm from the anal verge.

• Pathology- SRUS
• A year later....

• Rectal bleeding.
• Diarrhea.
• Abdominal pain.
• Colonoscopy: Normal mucosa. Mass proximal to the dentate line 1*1*2 cm.
• Biopsy: SRUS.
• Defecography: Anterior bulge of the rectum. Rectal intussusception.
• 7/6/2005- Anterior resection of Rectosigma and posterior rectopexy.

• Pathology:

• Follow up until 9/2008- No evidence of recurrence.
• Solitary rectal ulcer syndrome (SRUS) is an infrequent benign pathology.

• Its etiology remains obscure and the condition is frequently associated with pelvic floor disorders and difficult to treat.

• Occult / overt rectal prolapse with paradoxical contraction of the pelvic floor during defecation.

• Although Cruveilhier first reported four cases of chronic rectal ulcer in 1830, it was in 1964 that Madigan presented the first fully documented cases of solitary rectal ulcer.
Etiopathology

• Straining and paradoxical contraction of the pelvic floor during defecation results in prolapse/intussusception & high fecal voiding pressures that reduce local blood flow → ischemia and ulceration.

• Rectal mucosa is traumatized from the pressure of being prolapsed against a closed anal canal.

• Anorectal redundancy with a scarcity of mesorectosacral fixation.

• Mucosa of the anterior rectal wall, 7 - 10 cm above the anal verge, is the most common area of such prolapse (Rectorectal intussusception).
SRUS - Epidemiology

• Incidence is 1-3.6/100,000.

• Mean age of presentation – 49y.

• Gender distribution is either equal / slight female preponderance.
• The term SRUS is misleading because the lesions may be neither solitary nor ulcerated.

• Is a proctologic disease characterized by erythema, polypoid lesion and/or one or several ulcerations of the rectal wall.
• **SRUS** presents as a disorder of defecation with the following typical **features**:

• 1 - Passage of blood and mucus from the rectum associated with straining and a feeling of incomplete emptying.

• 2 - Evidence of rectal prolapse, either internal or external, with or without abnormal perineal descent on evacuation proctography.

• 3 - Sigmoidoscopic appearance varying from erythema to ulceration or polypoid lesions. These are commonly solitary but may be multiple. Although most commonly on the anterior rectal wall, they may be more extensive and even circumferential.

• 4 - Histological evidence of fibrous obliteration of the lamina propria with disorientation of the muscularis mucosa and extension of smooth muscle fibres into the lamina propria.
• **Differential diagnosis of the solitary rectal ulcer syndrome:**

• Inflammatory bowel disease.
• Infectious (amebiasis, lymphogranuloma venereum, secondary syphilis).
• Malignancy.
• Chronic vascular insufficiency (chronic ischemic colitis).
• Endometriosis.
• Colitis cystica profunda.
• Drug-induced (e.g., ergotamine tartrate-containing suppositories).
• Stercoral (pressure) ulcer.
• Trauma.
• Idiopathic.
• **Diagnostic tests**

• **Proctoscopy and biopsy with histologic changes** consists with SRUS (small percentage of cases, serrated polyps with focal loses of hMLH1).

• **Defecography – abnormal in 75%** (internal intussusception, pelvic floor descent, and delayed or incomplete rectal evacuation).

• **Colonic transit study (rule out colonic inertia).**

• **Manometry with balloon expulsion test** (non relaxing puborectalis).

• **ERUS – useful to distinguish SRUS from other conditions - e.g invasive cancer.** An inhomogeneous submucosa, a thickened muscularis propria, and thickening internal sphincter.
SRUS – Endoscopic Picture

- 40% - ulcers
- 20% - solitary ulcer
- 25% - polypoid lesion
- 18% - patchy mucosal erythema
- 30% - multiple lesions

• **Therapy**

• 1- Without complete external prolapse _restoration of normal habits of defecation:

  a) insoluble dietary fiber, fluid and laxatives.
  b) biofeedback (is more successful if the patient demonstrate anismus).
  c) Psychiatric evaluation for occult obsessive disorders.
- Surgical success is achieved in 50% to 79% of patients when prolapse is found, but is much less effective when no prolapse is found.

- Preoperative delayed, incomplete evacuation, tenesmus and digitation correlate with poor outcome after surgery.

- A. Transabdominal - Best results, fewer recurrences (3-5%).

  a) Open or Lap rectopexy (with or without mesh) - used for the treatment of complete rectal prolapse with SRUS. If there is a rectal prolapse or an occult prolapse, rectopexy should be the most advised procedure for abnormal anorectal symptoms.

  b) Sigmoidectomy & rectopexy.

- C) Colostomy
• **B. Transanal -**

• Altemeier.
• Delorme.

• STARR
• g) mucosectomy.

• h) TEM

• i) Argon plasma coagulation for bleeding
Bibliography

• Results of Behavioral Treatment (Biofeedback) for Solitary Rectal Ulcer Syndrome. Andrew J. Malouf et al. Dis Colon and Rectum 2001.