Rectal Prolapse: When the Rectum Slips Out

Rectal prolapse is a condition where all or part of the rectal wall "turns itself inside out" and can protrude through the anal opening. It is often a source of embarrassment and is easily confused with haemorrhoids - but the two conditions are very different and require their own specific treatments.

The condition affects approximately 2.5 in every 100,000 people annually, and 80-90% of patients are women over the age of 50 [1].

Three types of prolapse

1. **Complete rectal prolapse (procidentia)** - the entire wall of the rectum turns inside out, usually protruding 4-10 cm
2. **Internal/hidden prolapse (intussusception)** - the rectum folds in on itself but does not come out
3. **Mucosal prolapse** - only the lining of the rectum (mucosa) comes loose (resembles large haemorrhoids)

It is important to get the correct diagnosis, as the treatment varies for each type.

Symptoms

- A soft "lump" that comes out during a bowel movement or physical exertion
- Mucus or blood on your underwear
- A feeling of incomplete emptying
- **Faecal incontinence** - seen in 50-75% of patients at the time of diagnosis [2]
- **Constipation** - paradoxically common, as the prolapse can block the passage of stool
- Pain is rare (unlike with thrombosed haemorrhoids)

Risk factors

- Being female and aged over 50
- Multiple vaginal births
- Chronic constipation and straining during bowel movements
- Pelvic floor weakness
- Previous pelvic surgery
- Neurological diseases (MS, spinal cord injuries)
- Cystic fibrosis in children [3]

Investigation

The diagnosis is often made during a clinical examination, where the patient is asked to "bear down" while sitting on a toilet or lying on their left side. Additional investigations include:

- **Defaecography (MRI or X-ray)** for internal prolapse or suspected pelvic floor dysfunction [4]
- **Anorectal manometry** to assess the function of the sphincter muscle
- **Colonoscopy** to rule out a tumour or other cause, especially for first-time symptoms in those over 50

Treatment

Conservative treatment is rarely sufficient for a complete prolapse but can improve symptoms in cases of mucosal or internal prolapse:

- A fibre-rich diet and lactulose to combat constipation
- Pelvic floor exercises with a specialist physiotherapist
- Biofeedback training for concurrent incontinence

Surgery is the definitive treatment for complete prolapse and is divided into:

- **Abdominal procedures** (laparoscopic ventral mesh rectopexy, the D'Hoore procedure): Good long-term results, low recurrence rate (5-10%), and best suited for younger and fitter patients [5,6]
- **Perineal procedures** (Altemeier's or Delorme's procedure): Less invasive, shorter operating time, and typically used for older or more frail patients; recurrence rate 10-25% [7]

The choice between techniques is individualised and based on age, general health, concurrent incontinence/constipation, and the surgeon's experience. The ESCP (European Society of Coloproctology) recommends that the decision be made within a multidisciplinary pelvic floor team [8].

Prognosis and follow-up

After a successful operation, most patients experience a significant improvement in both the prolapse and any incontinence. However, constipation can remain a problem and requires ongoing dietary and pelvic floor therapy. Recurrence can happen years after the operation, and a follow-up with a surgeon is recommended if new symptoms appear [9].

When should you see a doctor?

- If you feel something "coming out" of your rectum
- Persistent faecal incontinence
- New symptoms from the rectum after the age of 50
- Bleeding that cannot be explained by haemorrhoids or an anal fissure

Rectal prolapse is neither life-threatening nor something to be ashamed of - but left untreated, the condition will worsen and significantly affect your quality of life. An early referral to a colorectal surgeon provides the best outcomes.

References

1. Kairaluoma MV, Kellokumpu IH. *Epidemiologic aspects of complete rectal prolapse.* Scand J Surg 2005;94(3):207-10.

2. Madiba TE, et al. *Surgical management of rectal prolapse.* Arch Surg 2005;140(1):63-73.
3. Bordeianou L, et al. *Clinical practice guidelines for the treatment of rectal prolapse.* Dis Colon Rectum 2017;60(11):1121-31.
4. Pannu HK, et al. *MR imaging of pelvic floor dysfunction.* Radiographics 2003;23(1):e1.
5. D'Hoore A, et al. *Long-term outcome of laparoscopic ventral rectopexy for total rectal prolapse.* Br J Surg 2004;91(11):1500-5.
6. Consten ECJ, et al. *Long-term outcome after laparoscopic ventral mesh rectopexy: an observational study of 919 consecutive patients.* Ann Surg 2015;262(5):742-7.
7. Senapati A, et al. *PROSPER: a randomised comparison of surgical treatments for rectal prolapse.* Colorectal Dis 2013;15(7):858-68.
8. Mercer-Jones MA, et al. *Consensus on ventral rectopexy: report of a panel of experts.* Colorectal Dis 2014;16(2):82-8.
9. Hotouras A, et al. *Recurrence of full-thickness rectal prolapse following surgical repair: a systematic review.* Colorectal Dis 2018;20(11):974-86.