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A rare case of rectal prolapse associated with rectal adenocarcinoma: Case report

Nadir bir olgu: Rektal prolapsus ile birlikte rektal adenokarsinom

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Despite the fact that colorectal polyps and solitary rectal ulcers may be present in conjunction with rectal prolapse, association between rectal prolapse and rectal cancer is very rare. As far as we could determine, there are only a few articles concerning rectal cancer in association with rectal prolapse in the literature. This case, a 63-year-old female patient, had suffered from a rectal prolapse since childhood and presented as a case of rectal cancer. At presentation, she complained of constipation and rectal bleeding for the previous six months. At physical examination there was a relaxed anal sphincter and a large reddish mass protruding via the anal canal when the patient strained. There was a fungating lesion in the upper left part of the rectal mucosa. An incisional biopsy was performed, the histopathological result of which was adenocarcinoma of the rectum. Changes in bowel habits, chronic constipation and chronic irritation seen in rectal prolapse may be responsible for the development of rectal cancer. Thus, a detailed history, digital rectal examination and rectosigmoidoscopic examination are important, particularly in patients with long-term rectal prolapse.

Keywords: Rectal cancer, rectal prolapse, adenocarcinom

Rektal prolapsus ile birlikte kolorektal polip, rektal soliter ülser görülmesine rağmen rektal prolapsus ile rektum kanseri birlikteliği oldukça nadir görülmektedir. Tespit edebildiğimiz kadarıyla dünya literatüründe sadece birkaç vaka yayınlanmıştır. Olgumuz rektal prolapsus ile birlikte rektum kanseri görülen 63 yaşında bir bayan idi. Anamnezinde çocukluğundan beri ıkınmakla ve öksürmekle belirginleşen rektal prolapsusu vardı. Son 6 aydır ara ara kabızlık, muköz akıntı, kanama, halsizlik ve gaita inkontinansı mevcuttu. Rektal muayenede elle geriye itilebilen total rektal prolapsus tespit edildi. Prolabe olan rektumun üzerinde yaklaşık 3x4 cm Uk tümöral kitle saptandı ve biyopsi alındı. Biyopsi sonucu adenokanser olarak değerlendirildi. Rektal prolapsusta görülen barsak alışkanlığındaki değişiklik, kronik kabızlık ve irritasyonun rektum kanseri gelişmesinden sorumlu olabileceği kanaatindeyiz. Bu nedenle uzun süre tedavi edilmemiş rektal prolapsuslu hastalarda detaylı bir anamnez, rektal tuşe ve rektosigmoidoskopik inceleme oldukça önemlidir.

Anahtar kelimeler: Rektum kanseri, rektal prolapsus, adenokarsinom

INTRODUCTION

Despite the fact that colorectal polyps and solitary rectal ulcers may be present with rectal prolapse, association between rectal prolapse and rectal cancer is very rare. As far as we could ascertain, there are only a few articles examining the relationship between rectal cancer and rectal prolapse in the literature (1, 2, 3). There are insufficient studies concerning this association (1, 3), which is important because of the differences in the surgical techniques for the management of these two conditions.

CASE REPORT

A 63-year-old female patient was admitted to our hospital with a diagnosis of rectal prolapse. She had had a protruding rectal mass since childhood caused by straining and coughing. At the onset, the mass protruded during defecation and disappeared spontaneously thereafter. In the last eight years, however, the mass required digital replacement after defecation. Four years previously, the patient underwent rubber-band ligation with a prediagnosis of internal anal hemorrhoids, but her symptoms continued. During the six months prior to presentation, she had complaints of constipation, mucous discharge, rectal bleeding, fatigue and fecal incontinence from straining and coughing. Results of the routine blood investigations were normal apart from anemia. Liver function tests and tumor markers were within normal levels. At

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the rectal examination, there was a manually reducible total rectal prolapse. There was a 3x4 cm tumoral mass on the prolapsed rectum 7 cm from the anus (Figure 1). Multiple biopsies were taken and the pathological result was adenocarcinoma of the rectum. There were no distant metastases in the routine investigations. Anal sphincter tone was found to be significantly reduced at anal electromyography (EMG). A Stappler-assisted low anterior resection with total mesorectal excision was performed. According to tumor-node-metastasis (TNM), the tumor was classified as Stage II A (T3 NOMO) (4). The patient was discharged on the seventh postoperative day with no complications. There was no local recurrence, no distant metastases and no recurrent prolapse in the first six months of the follow-up period.

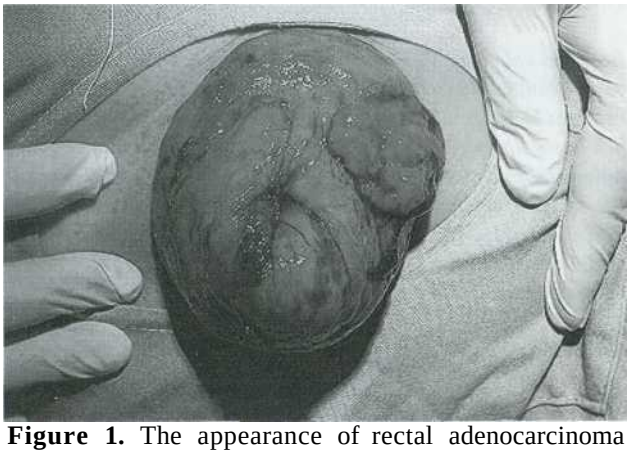

Figure 1. The appearance of rectal adenocarcinoma associated with rectal prolapse

DISCUSSION

Rectal prolapse is the cause of changes in the bowel habits of 10% of patients seeking medical examination (5, 6). Changes in the normal anatomic position of the rectum with subsequent protrusion of the rectum via the anal canal, together with changes in bowel habits and previous surgical interventions are factors responsible for the increased risk of rectal prolapse (7). Rectal prolapsus is promoted by constipation and other causes of increased intra-abdominal pressure (8). In Yamazaki et al.'s (3) patients, the cause of rectal prolapsus was attributed to straining from constipation exacerbated by cancer of the sigmoid colon. They concluded that a new onset of rectal prolapsus may be induced by colorectal cancer in some patients, and that rectal prolapse could be a symptom of colorectal cancer. They also suggested that a sudden onset of rectal prolapse should be screened for colorectal cancer. The patient in this case had a history of rectal prolapse since her childhood. Accordingly, we think that changes in bowel habits, chronic constipation and chronic irritation may have been responsible for the development of rectal cancer in this particular patient.

Rashid et al. (1) reported a retrospective study of 70 patients with rectal prolapse. According to this study, the prevalence of rectosigmoid carcinoma among patients with prolapse was 5.7%. Also, patients with rectal prolapse had a 4.2-fold increased risk of developing colorectal cancer compared with the control group. The authors concluded that because of the extent to which these patients represent the population of patients with rectal prolapse, routine initial screening of patients with symptomatic rectal prolapse using flexible sigmoidoscopy may be appropriate. The present case may be an indicator for the increased incidence of rectal cancer in patients with untreated chronic rectal prolapse.

As a result, we suggest that a detailed history, digital rectal examination and rectosigmoidoscopic examination are important, particularly in patients with long-standing rectal prolapse, due to the increased incidence of associated rectal cancer.

REFERENCES

1. Rashid Z, Basson MD. Association of rectal prolapse with colorectal cancer. Surgery 1996; 119(1): 51-5.
2. Cougard P, Richard D, Sauzedde JM, et al. Adenocarcinoma developing in a rectal prolapse. Apropos of a case. Ann Chir 1986; 40(1): 36-7.
3. Yamazaki T, Sakai Y, Sekine Y, et al. Sigmoid colon cancer presenting as complete rectal prolapse: report of a case. Surg Today 1999; 29(3): 266-7.
4. Longo WE, Johnson FE. The preoperative assessment and postoperative surveillance of patients with colon and rectal cancer. Surg Clin North Am 2002; 82: 1091-108.

Agachan F, Pfeifer J, Wexner SD. Defecography and proctography: results of 744 patients. Dis Colon Rectum 1996; 899-905.

Corman ML. Colon and Rectal Surgery (3rd ed). JB Lippincott Company, 1993.

Lisa KJ, Lin YJ, Orkun BA. The best operation for rectal prolapse. Surg Clin North Am 1997; 77: 49-70.

Karanjia ND, Rutter KRP. Solitary rectal ulcer and rectal prolapse. Curr Pract Surg 1994; 6: 59-64.