Massive Rectal Bleeding: Rare Presentation of Circumferential Solitary Rectal Ulcer Syndrome

Sir,

A 40-year-old male patient presented to emergency department with massive bleeding per rectum. He used to be chronically constipated and many a time either self digitation or spoon was required to remove the stool. Per abdominal examination was normal. Per rectal examination revealed clotted blood. He was hemodynamically unstable with pulse rate of 120/min, blood pressure of 80/60 mmhg, and respiratory rate of 24/min. Ultrasonography and skigram of abdomen were normal. Blood chemistry revealed hemoglobin of 6 gm% with leukocytosis and shift to left. Patient was resuscitated with Hartman's solution and 4 unit of packed cells .Colonoscopy was performed after stabilizing the patient. Colonoscopic finding revealed single, large ulcer involving whole circumference at 8 cm from the anal verge [Figure 1]. Histopathological examination of biopsy specimen showed mucosal thickening, elongation and distortion of the gland, proliferation of fibroblast, and obliteration of lamina propria by fibroblast.

Solitary rectal ulcer syndrome (SRUS) is an uncommon colorectal condition. The reported incidence is 1 in 100,000/year in 10 year study.[1] It is characterized by bleeding per rectum, perianal pain, mucous discharge, and difficulty in passing stool.[2] Diagnosis of SRUS depends on clinical manifestations, colonoscopic finding, and typical histopathological features. The terminology SRUS is misnomer; SRUS patients can have a single ulcer, multiple ulcers, or a non-ulcerated lesion. Non-ulcerated lesions may have polypoid and erythematous appearance. The ulcer is usually located on the anterior rectal wall. Men and women are equally affected. The syndrome is common in young adults. It is frequently associated with rectal prolapse.[3] Occult and overt rectal prolapse along with paradoxical contraction of pelvic floor muscles is the principle mechanism involved in the development of SRUS. The trauma to prolapsed mucosa may either be direct or due to shearing force. Self-rectal digitation has been suggested as a cause of SRUS and incidence varies from report to report with 100% being in one report. Although colitis cystica profunda is a closely related diagnosis, it is a pathological diagnosis. Biopsy helps in differentiating it from adenocarcinoma and prevents unnecessary operation. Defecography is the radiologic procedure of choice and reveals intussusception in 45–80% of patients. Other common findings on defecography are paradoxical puborectalis syndrome and thickened rectal mucosal fold. Rarely SRUS is associated with massive bleeding per rectum.[4] It may also be associated with rectal stricture.[4] Treatment modalities include dietary management, biofeedback, salicylate enema, steroid enema, and local injection of corticosteroid.[5] Severe symptoms (e.g. massive bleeding, spasm, and severe pain) may require temporary colostomy. Surgical therapy to correct rectal prolapse is indicated in highly symptomatic patients who do not respond to conservative management.

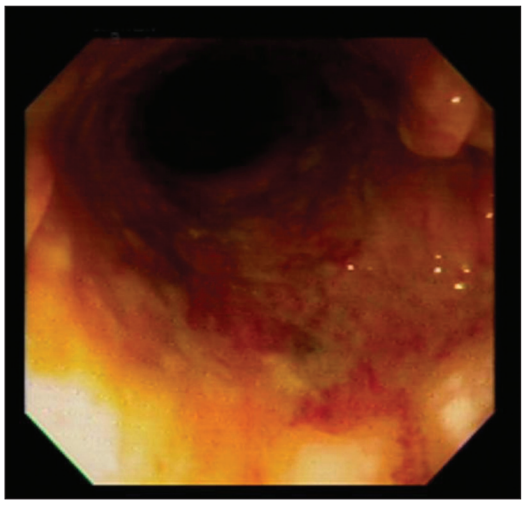

Figure 1: Circumferential solitary rectal ulcer

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REFERENCES

1. Martin CJ, Parks TG, Biggart JD. Solitary rectal ulcer syndrome in Northern Ireland. 1971–1980. Br J Surg 1981;68:744-7.
2. Madoff RD. Rectal prolapse and intussusception. Fundamentals of Anorectal Surgery. 2nd ed. In: Beck DE, Wexner SD, editors. London: WB Saunders Co; 1998. p. 99.
3. Beck DE. Colitis cystica profunda. In: Johnson LR, editor. Encyclopedia of Gastroenterology. San Diego: Elsevier Science; 2003. p. 374-5.
4. Vaizey CJ, van den Bogaerde JB, Emmanuel AV, Talbot IC, Nicholls RJ, Kamm MA. Solitary rectal ulcer syndrome. Br J Surg 1998;85:1617-23.
5. Dehghani SM, Haghighat M, Imanieh MH, Geramizadeh B. Solitary rectal ulcer syndrome in children: A prospective study of cases from southern Iran. Eur J Gastroenterol Hepatol 2008;20:93-5.

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DOI: 10.4103/1319-3767.82592