Co-Management and Referral Guidelines

Management of Rectal Prolapse

Legacy Medical Group–Gastrointestinal Surgery

Phone: **503-413-5514**
Fax: **503-413-5594**

Introduction

Rectal prolapse (procidentia) is the circumferential protrusion through the anus of all layers of the rectal wall. While this condition is benign, it can be debilitating due to pelvic or rectal discomfort, drainage of mucus or blood and difficult defecation or incontinence.

It can sometimes be difficult to differentiate between full-thickness rectal prolapse and concentric internal hemorrhoidal prolapse; rectal prolapse is characterized by concentric folds rather than linear protrusion.

Rectal prolapse is most commonly diagnosed in women aged 50 and older. Despite its association with multiparity and obstetric injury, approximately one-third of women with rectal prolapse are nulliparous. Men with rectal prolapse tend to be age 40 or younger. In younger patients, it is associated with autism, developmental delay and psychiatric illness requiring long-term medications.

Patients with rectal prolapse often experience fecal incontinence (50–75 percent), constipation (25–50 percent) and associated pelvic organ prolapse (40 percent). They may develop recurrent urinary tract infections related to stool or mucus drainage. Rectal prolapse can be associated with redundant sigmoid colon, poor anal sphincter tone and neurologic disease, as well as colorectal tumors, ulcers or other lesions.

Evaluation and Management

Evaluation

Initial evaluation includes a thorough history, particularly eliciting a history of rectal prolapse or sensation of the rectum "falling out," and whether this spontaneously retracts or is manually reducible. Other symptoms may include chronic constipation, fecal or urinary incontinence, perineal "bulges" or apparent prolapse, rectal bleeding or mucus drainage, rectal pain, urinary dysfunction.

Exam

Physical exam should include focused perineal exam with digital rectal exam, and observation of the rectum and perineum, introitus with valsalva to evaluate for prolapse or bulging. This portion of the exam is usually most comfortably performed in the office in left lateral position. Prolapsing rectal mucosal tissue should be assessed for bleeding and/or evidence of mucosal ischemia such as dark, sloughing tissue. Prolapsing tissue should be manually reduced as able by applying gentle pressure.

However, note that prolapse may not be apparent without straining on the commode. This can be deferred for the specialist visit.

Diagnostic testing/imaging

Endoscopy and further imaging can be deferred prior to specialist evaluation and generally will include:

- Office anoscopy/proctoscopy
- Colonoscopy should be performed if the patient is not up-to-date or if last colonoscopy predates development of symptoms.

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- Cystodefecography is a radiologic test often ordered to assess for complex organ prolapse.
- Motility and physiologic testing are sometimes considered in patients with history of chronic constipation to assess for colonic inertia and pelvic floor dysfunction.

Treatment

Nonoperative management

This generally involves avoidance of straining and reduction of rectal prolapse.

- Patients should be encouraged to manually reduce the prolapse as able and reassured that this is appropriate.
- Adding fiber supplements and stool softeners may decrease straining with defecation and decrease severity of prolapse symptoms.
- Patients may benefit from pelvic floor physical therapy to address contributing factors such as chronic straining and pelvic floor/outlet dysfunction

Operative management

Surgical repair is the mainstay for treatment of rectal prolapse.

There are two general approaches: abdominal and perineal (Altemeier procedure).

In patients with acceptable risk, procedures incorporating a transabdominal rectal fixation (rectopexy) are typically the procedure of choice. This can be generally be performed using a minimally invasive laparoscopic or robotic approach, with or without mesh fixation, and is generally found to have a lower risk of recurrence compared to perineal approaches. Resection of the sigmoid colon is generally reserved for patients with chronic constipation.

Patients with short, full-thickness prolapse can be treated with a mucosal sleeve resection via a perineal approach (Delorme procedure).

Patients with more extensive prolapse who are not candidates for an abdominal operation may be treated with a perineal rectosigmoidectomy, or Altemeier procedure.

When to refer

Urgent referral — Attempt to reduce the prolapse with gentle pressure is appropriate, but it often will not stay reduced. Patients who experience rectal prolapse that cannot be reduced and who experience associated pain or ongoing bleeding are appropriate for urgent referral to the colorectal specialists at Legacy Medical Group–Gastrointestinal Surgery. These patients may require local treatment to permit reduction in anticipation of surgical repair, and in rare cases may require emergent surgical repair.

Routine referral — Patients with concern for rectal prolapse or possible severe hemorrhoidal disease that is reducible or not severely symptomatic are appropriate for routine referral to the colorectal specialists at Legacy Medical Group–Gastrointestinal Surgery.

Referral process

Epic referral may be placed to "Pelvic Floor" or call Legacy Medical Group–Gastrointestinal Surgery at 503-413-5514. For urgent referrals, call Legacy Medical Group–Gastrointestinal Surgery at 503-413-5514.

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