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A case of solitary rectal ulcer syndrome

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Abstract
A solitary Rectal ulcer is an uncommon benign disease. Men and women are affected equally, with a predominance in women. SRUS clinical features include rectal bleeding, copious mucus discharge, prolonged excessive straining, perineal and abdominal pain, feeling of incomplete defecation, constipation, and rectal prolapse [1, 2]. Though SRUS is defecation disorder, its pathogenesis still remains unclear. Here 57 F with SRUS underwent Resection Rectopexy with covering ileostomy. To conclude that the surgery is the treatment of choice after the number of conservative steps.

Keywords: solitary rectal ulcer syndrome, anterior resection, pathogenesis, intussusception

Introduction
A solitary Rectal ulcer is an uncommon benign disease. Men and women are affected equally. SRUS clinical features include rectal bleeding, copious mucus discharge, prolonged excessive straining, perineal and abdominal pain, feeling of incomplete defecation, constipation, and rectal prolapse, It is usually occurs 4-10cm from anal margin. Though SRUS is defecation disorder, its pathogenesis still remains unclear. The presentation are wide array from a patchy erythematous lesion to polyps, and well developed ulcers [3]. Its prevelance is not clearly known but it affects 1 in 100,000 and to a common in women than men [4].

Clinical Case
A 57 yr old female came with complaints of bleeding from anal region and immediately after passing stools for 7 years. Complaints of pain while passing stools and after defecation near anal region for 7 years, sudden onset , gradually progressive non – radiation, no aggravating and relieving factors.H/o Lateral sphincterotomy done 7 years ago and biopsy was sent and diagnose to have a solitary rectal ulcer. Examination: Per Rectum: Sphincter tone normal, Tenderness present, chronic fissure present, No Sinuses, skin tags. 2x2 cm mass palpable. Blood investigations done and found to be normal. Sigmoidoscopy done and showed Solitary Rectal Ulcer and biopsy done. Histopathology – Showed crypt hyperplasia and some glands show elongation with focal dilation, thickened muscularis mucosa with splayed fibres is seen between the glands. Impression – Suggestive of solitary rectal ulcer syndrome. Patient underwent Lower Anterior Resection of Rectum with Covering Ileostomy. Specimen Biopsy – Shows focal mucosal ulceration with cystic hyperplasia, elongation and edematous stroma with chronic inflammatory cells suggestive of Mucosal Prolapse syndrome.

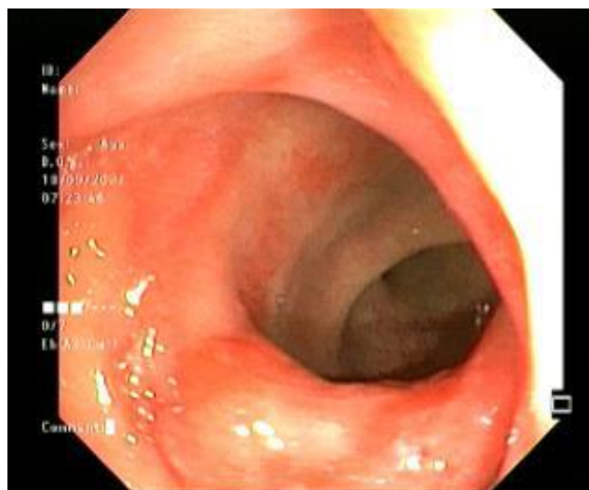

Fig 1: *Sigmoidoscopy of SRUS*

Discussion

SRUS is a chronic, benign disorder characterized by single or multiple ulcerations of the rectal mucosa, with the passage of blood, mucus with straining .Solitary ulcer is a misnomer because ulcer are found in 40% of patients, while 20% of patients have a solitary ulcer and the rest of lesions may appear differently including hyperemic mucosa to broad based polypoid lesion. The underlying etiology are not fully understood but multiple factors are involved, in which the most accecpted theories are related to direct trauma or local ischemia. Mucosal prolapse is the most common underlying pathogenetic mechanism in SRUS. This leads to poor blood flow, venous congestion and edema in the mucosal lining of rectum and ischemic changes with ulceration. Rectal mucosal blood fow has been found to be reduced in SRUS, suggesting impaired autonomic cholinergic gut nerve activity. In children, secondary to chronic mechanical and ischemic trauma, inflammation by hard stools and intussusceptions of the rectal mucosa, some histological features of SRUS can be seen.

It is usually present on distal rectum on the anterior wall. clinical features include bleeding, mucus discharge , prolonged excessive straining, perineal and abdominal pain , feeling of incomplete defecation , constipation and rectal prolapse [4, 5].

Evaluation of SRUS should include anorectal manometry, defecography and either colonoscopy and barium enema.Biopsy of the mass and ulcer is mandatory to exclude malignancy or infection (CMV). There are no specific treatment for SRUS, but there are multiple options. The treatment of SRUS are vast form conservative management. medical therapy and surgery and the choice of treatment depends on the severity of symptom and whether there is a rectal prolapse. Our patient initially had difficulty in passing stools when she developed the symptoms 7 years back with bleeding. Initially different modality of conservative measures such as diet, laxatives and enemas of sulfasalazines and corticosteroid, but the patient had no significant improvement and it affected the lifestyle modality. Later patient underwent lateral shpincterotomy as patient had increased sphincter tone and bleeding and biopsy was done and patient was diagnosed with SRUS. Many empirical treatment have been tried and there is very little evidence that any of them have been effective. The patient treatment starts with the dietary and lifestyle modifications, such as high fibre diet, regulation of toilet habits, to avoid straining while passing stools. The initial treatment starts by high fibre diet along with stool softners and bulking laxatives and avoidance of straining while passing stools. These modifications have been found to be effective in to patients with mild to moderate symptoms and in absence of mucosal prolapse. The conservative management are less useful when SRUS is associated with an advanced grade of rectal intussusception, inflammation and fibrosis and mucosal prolapse. Topical treatment like sucralfate, salicylate, corticosteroids, sulfasalazine and topical fibrin sealant have various responses and improvement of symptoms.

Fig 2: *Sigmoidoscopy of SRUS*

Surgery is final option and for patients not responsive to conservative measures and bio feedback. Surgery is warranted in case of rectal prolapse. The variety of surgical treatment include excision of the ulcer, treatment of internal or overt rectal prolapse and colostomy. The indications for surgery include the failure of the conservative treatment to control symptoms and affecting the lifestyle of the patient. Before proceding with surgery patients with defecatory dysfunction deserve a thorough evaluation that includes: Dynamic imaging (RX- colpocystodefecography), Extensive manometry including defecometry, Neurologic investigation if needed and rectoscpy with biopsy. In this case, the patient underwent Low anterior resection with covering ileostomy, and the ulcer of size 2x1 cm present in anterior rectal mucosa 7cm proximal to anal verge. Post operatively the patient improved.

Conclusion

SRUS is a chronic benign disorder in which the pathology is not clearly understood. There are wide variety of treatment which starts with conservative management like topicals, laxatives and dietary habits and behavior

modification. But in case of no improvement of symptoms and mucosal prolapse surgery is the treatment of choice.

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