



**Mucosal Prolapse/ Solitary Rectal Ulcer
Syndrome**

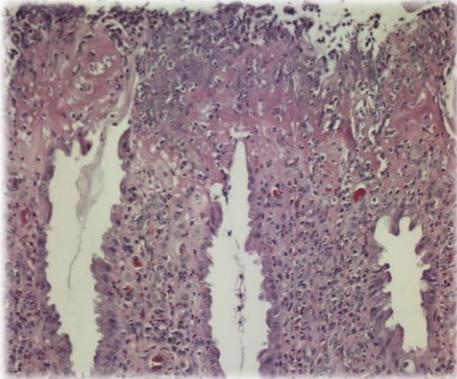


Fig. 1- The rectal crypts underneath the fibrinopurulent exudate show reactive epithelial changes with regenerative atypia but negative for dysplasia.

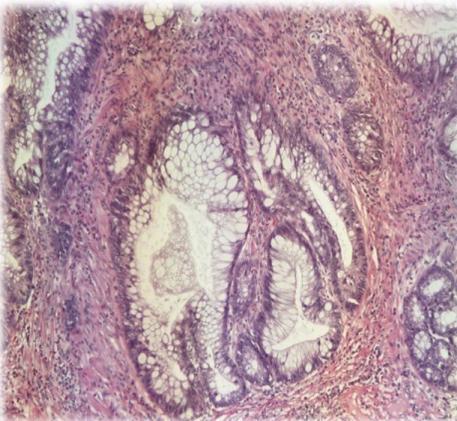


Fig. 2 Hyperplastic crypts with marked architectural disarray. Smooth muscle proliferation, fibroblasts and collagen deposition within the lamina propria (fibromuscular hyperplasia).

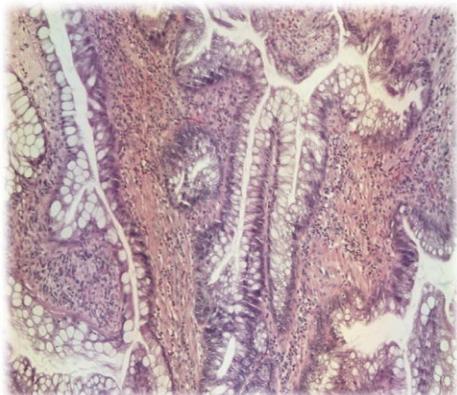


Fig. 3 Smooth muscle fascicles extend perpendicularly from the muscularis mucosa high into the lamina propria (fibromuscular hyperplasia).



Fig. 4

Clinical History: 46 year old male with recurrent episodes of anal discomfort and rectal nodular growth on self examination for the last 3 years. Alternating constipation and soft defecation. No rectal bleeding. No anal or abdominal pain. On rectal exam a 1.5 cm. anal soft mucosal nodule was noted. The patient constipation was somewhat improved with a high fiber diet and bulking supplements. Topical glucocorticoids were not helpful. After excluding a neoplastic lesion the patient was referred to a Colorectal surgeon for evaluation.

Endoscopic Findings: A 2.0 cm sessile, polypoid and friable ano-rectal mass was noted. No ulcerations were seen. See Figure 4.

Histologic Findings: Rectal biopsies revealed a villiform mucosa with a focally eroded surface, covered by a fibrinopurulent exudate. The histologic features, as demonstrated on figures 1-3, are those associated with mucosal prolapse.

Discussion:

Major symptoms of Mucosal Prolapse/ Solitary Rectal Ulcer Syndrome include severe straining, tenesmus, constipation and/or diarrhea, anorectal or abdominal pain, rectal bleeding and a mucous discharge. It is not infrequent for patients to assist rectal evacuation by digital manipulation.

The pathogenesis of this entity involves malfunction of the puborectalis muscle and anal sphincter. Inappropriate muscle contraction results in chronic excessive straining upon defecation leading to increase intrarectal pressure and mucosal prolapse.

The majority of the lesions of mucosal prolapse occur on the anterior rectal wall, predominantly within reach of a rectal exam. Ischemia of the prolapsed mucosa can lead to ulceration. These rectal ulcers are usually flat, indurated, well demarcated lesions with irregular borders. Following repeated trauma, there can be an exaggerated reparative process developing into a polypoid lesion. These polypoid masses are sessile and can range up to several centimeters in diameter. Hence, the clinical importance for recognizing this entity, and its differential distinction from adenoma and adenocarcinoma of the rectum.

Local excision, diversion and rectopexy are surgical alternatives. Anti-prolapse surgeries have a satisfactory long term outcome in 60% of patients. Minimally invasive laparoscopic mesh rectopexy is an alternative for selected patients but further studies are needed.