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Unusual Presentation of Solitary Rectal Ulcer Syndrome With Chronic Diarrhoea

KEYWORDS: Solitary rectal ulcer syndrome, chronic diarrhea, unusual presentation

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ABSTRACT *Solitary rectal ulcer syndrome (SRUS) is an rare benign disease, characterized by a combination of symptoms & clinical findings. Patients usually present with rectal bleeding, copious mucus discharge, prolonged excessive straining, pain, feeling of incomplete defecation, constipation, and rarely, rectal prolapse. We present a case of a 22year old woman with chronic diarrhea who was found to have rectosigmoid lesion on colonoscopy, which on biopsy, reported as solitary rectal ulcer syndrome.*

INTRODUCTION:

We present a case of a 22 year old woman who was having episodes of diarrhea on & off since 2 years. As other routine investigations were normal, she underwent colonoscopy which revealed a rectosigmoid lesion which was biopsied and reported as solitary rectal ulcer syndrome. It is an unusual presentation of solitary rectal ulcer syndrome which usually presents with clinical symptoms such as rectal bleeding, copious mucus discharge, prolonged excessive straining, perineal and abdominal pain, feeling of incomplete defecation, constipation, and rarely, rectal prolapse. Our case highlights that though constipation is the main presenting feature of solitary rectal ulcer syndrome, diarrhea can also be the main presenting complaint.

CASE HISTORY:

A 22 year old female came to our out-patient department with history of chronic diarrhea more than 2 years occurring on and off. She had few episodes of constipation in 2years period. Apart from that, there was no history suggestive of rectal bleeding, abdominal pain & rectal prolapse. She was not a known diabetic or hypertensive. She was not on any regular medication. Although she has consulted many specialists, there was no relief of symptoms.

When she reported at our institution, her vitals were stable; on per abdominal examination there was non-specific mild tenderness. On digital rectal examination, there was tenderness, no masses were felt, gloved finger was not stained with blood.

CECT abdomen showed long segment circumferential wall thickening at the rectosigmoid junction causing significant luminal narrowing.

Colonoscopy showed ulcerated narrowing with a polypoidal growth at about 15cms from the anal verge, which on biopsy was reported as solitary rectal ulcer syndrome.

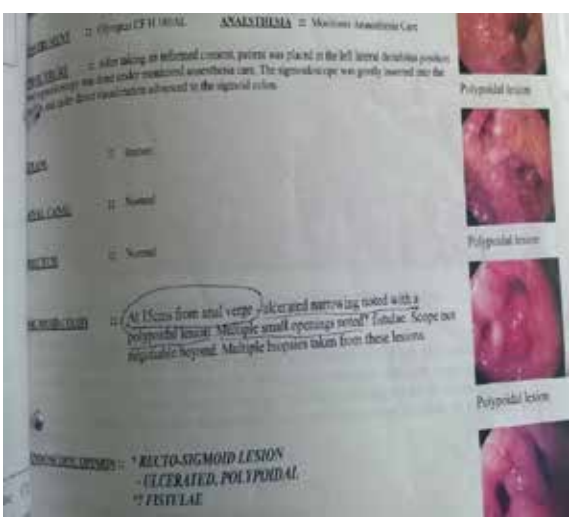

FIG 1 SHOWS COLONOSCOPY REPORT

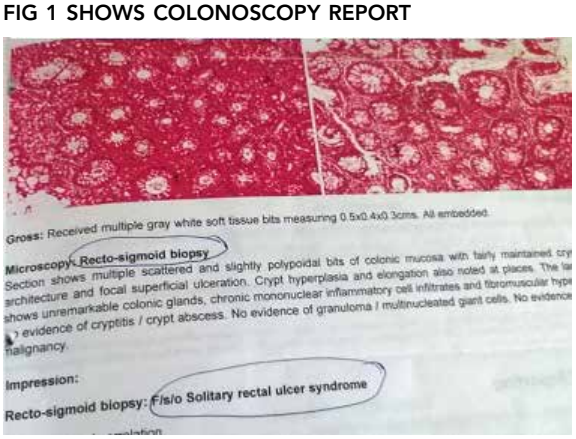

FIG 2 SHOWS BIOPSY REPORT

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TREATMENT: She was operated under general anaesthesia. Resection of the involved segment & end- to- end anastomosis was done.

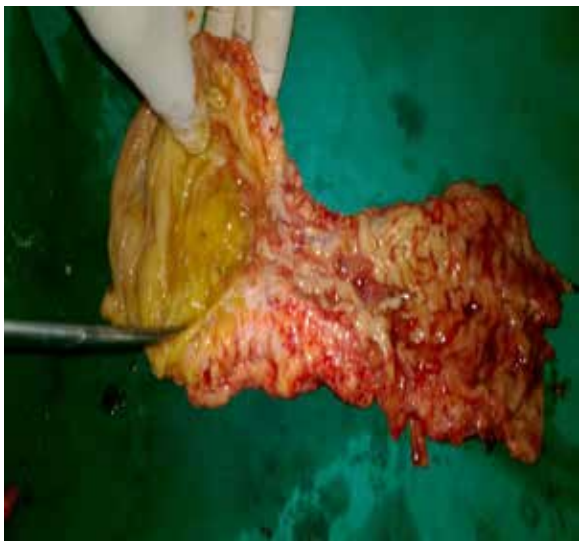

FIG 3 RESECTED SEGMENT

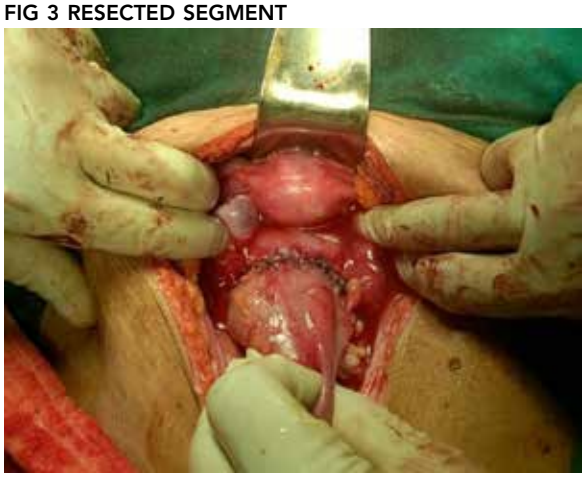

FIG 4 END TO END ANASTOMOSIS

POST-OPERATIVE PERIOD:
Post-operatively, the patient recovered well, with active bowel sounds on the 3rd post-operative day. She passed stools on the 5th post-operative day. Patient was discharged on the 7th post-operative day.

Biopsy report of the specimen was corroborative with colonoscopic biopsy finding.

FOLLOW UP:
Patient was doing well after 1 month of follow up. There is no recurrence of symptoms and her bowel movements are normal.

DISCUSSION:
The solitary rectal ulcer (SRU) is a benign lesion of adults of either sex, which presents with chronic constipation, peculiar defecatory disorders, rectal prolapse and smaller psychological abnormalities[1].Clinical features include rectal bleeding, copious mucus discharge, prolonged excessive straining, perineal and abdominal pain, feeling of incomplete defecation, constipation, and rarely, rectal prolapse[2]. The diagnosis of SRUS is usually made on the basis of a combination of presenting symptoms and endoscopic and histological appearances[3]. Colonoscopy and biopsy of normal and abnormal-looking rectal and colonic mucosa should be performed. It has been reported that the ulcer is usually located on the anterior wall of the rectum and the distance of the ulcer from the anal margin varies from 3 to 10 cm[4]. Key histological features include fibromuscular obliteration of the lamina propria, hypertrophied muscularis mucosa with extension of muscle fibers upwards between the crypts, and glandular crypt abnormalities[5]. Clinical picture and endoscopic biopsies lead to the diagnosis. Barium enema, defecography, transrectal ultrasound, manometry and electromyography have an additional role. Barium enema shows granularity of the mucosa, polypoid lesion, rectal stricture and ulceration, and thickened rectal folds; all of which are nonspecific findings[6]. Anorectal manometry and electromyography provide useful information about anorectal inhibitory reflex, pressure profiles, defecation dynamics, and rectal compliance and sensory thresholds[7]

The treatment of solitary rectal ulcer syndrome (SRUS) remains problematic and is less than idea. Conservative therapy with dietary fiber, bowel retraining, and bulk laxatives should be employed. If symptoms persist, the patient should receive a trial of sucralfate enemas for 6 weeks. Individuals who respond should continue conservative therapy[8]. Surgical management is by an excisional surgery, or a rectopexy if there is prolapse. Fecal diversion and rectocolic resection are considered only for patients with obstinate and severe symptoms. Even in patients who seem to advocate a surgical approach, it is important to heal a dyskinetic puborectalis muscle[9] The diagnosis is made clinically,endoscopically and histologically.Symptoms may resolve spontaneously or may require treatment. A variety of therapie has been tried.Several therapies thought to be beneficial include topical medications,behavior modification supplemented by fiber,biofeedback and surgery. Patient education and a conservative,stepwise individualized approach remain paramount in the management of this syndrome[10].

CONCLUSION:
Our case has highlighted the unusual presentation of solitary rectal ulcer syndrome which is usually associated with chronic constipation but rarely can present with diarrhoea.

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