Rectal Prolapse Information Leaflet

What is rectal prolapse?

The colon and rectum refers to the large intestine or bowel, which forms the lowest part of the digestive system, and which ends at the anus (opening through which solid food waste or stool leaves the body).

A rectal prolapse occurs when the normal supports of the rectum (the lower end of the colon just above the anus) become weakened and the rectum drops down outside the anus. This often happens because the anal sphincter muscle (the muscle of the anus) has become weak and there is difficulty in controlling the bowels with leakage of stool or jelly like material called mucus. While this condition occurs in both sexes, it is much more common in women than men.

Why does it occur?

There are several reasons why rectal prolapse may develop.

- A lifelong habit of straining to have bowel movements
- As a result of childbirth which may show later in life
- Rarely it may be due to a genetic (which runs in families) connective tissue illness
- As part of the natural ageing process when ligaments (connecting tissue which support the rectum inside the pelvis) weaken and the anal sphincter muscle loses strength.
- Sometimes it can be part of wider more general problems in the pelvic floor area and the muscular base which supports the bladder, rectum and genital area (private parts). In this case there may be problems of leaking urine (fluid produced by the kidneys) and other pelvic organs may drop down out of normal position.
- Neurological problems (the brain, spine and nerves) may lead to prolapse.

In most cases, no single cause can be pinpointed or identified.

Is rectal prolapse the same as haemorrhoids (piles)?

No. Some of the symptoms may be the same: bleeding and/or tissue that protrudes out of the rectum. Rectal prolapse, however, involves a part of the bowel located higher up within the body, while haemorrhoids develop near the anal opening.

How is rectal prolapse diagnosed?

We will need to see you in clinic to assess your symptoms and to carry out a physical examination. A doctor can often diagnose this condition with a careful history by asking you a series of questions and a complete anorectal (anus and rectum)

examination. You may be asked to "strain" or push as if having a bowel movement or even sit on a commode (portable toilet) and bear down in order to show the size of the prolapse.

Occasionally, a rectal prolapse may be "hidden" or internal, making the diagnosis more difficult. In that case, an x-ray examination called a Proctogram may be helpful. A Proctogram is a series of images of the way the waste passes through the whole length of the bowel. These tests are x-ray studies that look at how well your large bowel works and to see how the pelvic organs (the organs and area around the rectum) are supported (how they hold up) when the bowel is emptied. It can help your doctor determine if surgery may be beneficial and which operation may be appropriate.

We may also perform Anorectal Physiology studies on the anal sphincter (muscle of the anus) to look at its structure and function (how it is working). For these tests small catheters or tubes are gently inserted through the anus and measurements are taken.

How is rectal prolapse treated?

Although constipation and straining may contribute or add to the development of rectal prolapse, simply correcting these problems may not improve the prolapse once it has developed. There are many different ways surgically to correct rectal prolapse.

There are two ways of operating for rectal prolapse; one through the abdomen (tummy) called a Rectopexy and the other through the anus called the “perineal” approach.

For some patients who are suitable it may be possible to do the abdominal repair through key hole surgery (an operation done through a small hole or holes in the tummy with no need for a much larger cut as is the case with open surgery). The decision to recommend an abdominal rectal surgery or perineal surgery takes into account many factors, including age, physical condition, extent of prolapse and the results of various tests.

How successful is treatment?

A great majority (more than half) of patients are completely relieved of symptoms, or are significantly helped, by the appropriate procedure. Success depends on many factors, including the status of a patient's anal sphincter muscle before surgery, whether the prolapse is internal or external and the overall condition of the patient.

If the anal sphincter muscles have been weakened, either because of the rectal prolapse or for some other reason, it is often possible for this muscle to regain strength after the rectal prolapse has been corrected. It may take up to a year before a patient is able to see how much bowel function has been improved by the surgery. Chronic constipation (long term) and straining after surgical correction should be avoided.