
Rectal prolapse

Summary

- We do not know the exact cause of rectal prolapse, but risk factors include chronic constipation, straining to pass bowel motions, and weakened pelvic floor muscles.
 - Treatment includes surgery, performed through the abdomen or via the anus, to tether the rectum into place.
 - A diet that successfully treats constipation is often all that's needed to cure rectal prolapse in young children.
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The rectum is the last 20 cm or so of the large bowel. It is the temporary storage area for bowel motions. Rectal prolapse occurs when the rectum turns itself inside out and comes out through the anus. Without treatment, the rectum will eventually need to be pushed back in manually.

Women are six times more likely to suffer rectal prolapse than men. Children of both sexes under the age of three years are also commonly affected by rectal prolapse, although the prolapse tends to resolve by itself without the need for surgery.

In the early stages of rectal prolapse, a portion of the rectum slips out while passing a bowel motion, but it goes back inside by itself.

Symptoms of rectal prolapse

The symptoms of rectal prolapse depend on the severity, but can include:

- Pain and discomfort felt deep within the lower abdomen
- Blood and mucus from the anus
- The feeling of constipation, or that the rectum is never completely emptied after passing a motion
- Difficulties passing a bowel motion
- Protrusion of the rectum through the anus
- The need to use huge quantities of toilet paper to clean up following a bowel motion
- Leakage of liquefied faeces, particularly following a bowel motion
- Faecal incontinence, or reduced ability to control the bowels.

Types of rectal prolapse

Rectal prolapse is graded according to its severity, including:

- Internal prolapse – the rectum has prolapsed, but not so far as to slip through the anus. This is also known as incomplete prolapse
- Mucosal prolapse – the interior lining of the rectum protrudes through the anus
- External prolapse – the entire thickness of the rectum protrudes through the anus. This is also known as complete or full-thickness prolapse.

Causes of rectal prolapse

The exact cause of rectal prolapse is unknown, but risk factors include:

- Chronic constipation
 - Straining to pass bowel motions
 - Weakened pelvic floor muscles
 - Weakened anal sphincter muscles
 - Weakening of the muscles associated with ageing, since rectal prolapse is more common in people aged 65
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years and over

- Genetic susceptibility, since it appears that some people with rectal prolapse have a blood relative with the same condition
- Parasitic infection, such as schistosomiasis – very rare in Australia
- Any condition that chronically increases pressure within the abdomen, such as benign prostatic hypertrophy, or chronic obstructive pulmonary disease (COPD)
- Structural problems with the ligaments that tether the rectum to its surrounds
- Congenital problems of the bowel, such as Hirschsprung's disease or neuronal intestinal dysplasia
- Prior trauma to the lower back
- Disc disease in the lower back.

Complications of rectal prolapse

Complications of rectal prolapse include:

- Risk of damage to the rectum, such as ulceration and bleeding
- Incarceration – the rectum can't be manually pushed back inside the body
- Strangulation of the rectum – the blood supply is reduced
- Death and decay (gangrene) of the strangulated section of the rectum.

Diagnosis of rectal prolapse

Rectal prolapse is diagnosed by examination. In cases where the rectum goes back inside by itself after passing a bowel motion, the person may have to bear down during examination by the doctor to show the prolapse in order to confirm the diagnosis.

In cases of suspected internal prolapse, diagnostic tests may include ultrasound, special x-rays and measurement of the anorectal muscle activity (anorectal manometry). If the person has experienced rectal bleeding, the doctor may want to do a number of tests to check for other conditions such as bowel cancer.

About 11 per cent of children with rectal prolapse have cystic fibrosis, so it is important to test young people for this condition too.

Treatment for rectal prolapse

Treatment depends on many individual factors, such as the age of the person, the severity of the prolapse, and whether or not other pelvic abnormalities are present (such as prolapsed bladder). Treatment options can include:

- Diet and lifestyle changes to treat chronic constipation – for example, more fruit, vegetables and wholegrain foods, increased fluid intake and regular exercise. This option is often all that's needed to successfully treat rectal prolapse in young children
- Securing the structures in place with surgical rubber bands – in cases of mucosal prolapse
- Surgery.

Surgery for rectal prolapse

Surgery is sometimes used to secure the rectum into place. It can be performed through the person's abdomen or via their anus. One operation involves tethering the rectum to the central bone of the pelvis (sacrum). Another operation is to remove the prolapsed part of the rectum and to rejoin the bowel to restore near-normal bowel function.

Although surgery through the abdomen may give better long-term results, older people may be advised to undergo surgical correction via the anus, since it is easier to recover from this procedure.

Before surgery for rectal prolapse

The day before surgery, you will be asked to fast, and may need to drink a special preparation to help flush out your bowels. Once you are in hospital, the anaesthetist will visit you to see what sort of anaesthetic is best for you. You may be given medication in the hours before the operation to prepare you for anaesthesia and make you feel drowsy.

Rectal prolapse operation procedure

The various types of surgery include:

- Laparotomy (open abdominal surgery) – the surgeon uses a single, large incision (cut) in the abdomen. Then the surgeon carefully moves aside the overlying organs. To stop the rectum prolapsing, it is lifted, pulled straight and stitched directly to the inner surface of the sacrum (central bone of the pelvis). Sometimes, a short length of bowel may be removed
- Laparoscopy (keyhole abdominal surgery) – laparoscopy may be possible in some cases. This involves inserting slender instruments through a number of small incisions in the abdomen. Recovery time following laparoscopy is usually quicker than open surgery
- Anal surgery – under anaesthesia, the surgeon gently pulls out the prolapsed bowel through the anus. The prolapsed section of bowel is usually removed and the structural damage repaired. The bowel is rejoined and returned back through the anus to restore normal bowel function and appearance.

Other forms of treatment for rectal prolapse

Surgery is the best option for severe rectal prolapse. Other possible forms of treatment may include:

- Lifestyle changes – including high-fibre diet, drinking plenty of water and getting regular exercise
- Change to toileting habits – such as not straining when trying to pass a bowel motion. This may require using fibre supplements or laxatives.

Immediately after surgery for rectal prolapse

After your operation for rectal prolapse or rectocele, things you can expect include:

- Hospital staff will observe and note your temperature, pulse, breathing and blood pressure.
- You will have an intravenous fluid line in your arm to replace fluids in your body.
- You will receive pain-relieving medications. Tell your nurse if you need more pain relief.
- You may have a catheter to drain off urine for the next day or so, or until you can empty your bladder by yourself.
- If you have a vaginal pack, this will be taken out later the same day or the day after surgery.
- You may be in hospital for three to six days following surgery.
- You will need to make follow-up appointments with your doctor.

Complications of surgery for rectal prolapse

Possible complications of surgery include:

- Allergic reaction to the anaesthetic
- Haemorrhage
- Infection
- Injury to nearby nerves or blood vessels
- Damage to other pelvic organs, such as the bladder or rectum
- Death (necrosis) of the rectal wall
- Recurrence of the rectal prolapse.

Taking care of yourself at home after surgery for rectal prolapse

Be guided by your doctor, but general suggestions include:

- Rest as much as you can.
- Avoid heavy lifting or straining for a few weeks.
- Don't strain on the toilet.
- Take measures to prevent constipation, such as eating high-fibre foods and drinking plenty of water.
- After rectocele surgery, expect bloody vaginal discharge for about four weeks.
- Contact your doctor if you experience any unusual symptoms, such as difficulties with urination, heavy

bleeding, fever, or signs of infection around the wound sites.

- You can expect to return to work around six weeks after surgery.
- Attend follow-up appointments with your surgeon.

Long-term outlook after surgery for rectal prolapse

While surgery through the abdomen gives better results, older people may be advised to undergo surgical correction of rectal prolapse via the anus, since this procedure is less stressful on the body.

Surgery gives good results in most cases of rectal prolapse, but some people may find that symptoms such as constipation or the inability to completely empty the bowels continue.

Unfortunately for women with rectocele, the problem will recur after surgery in about 10 per cent of cases.

Where to get help

- Your doctor
- Colorectal or general surgeon

Things to remember

- We do not know the exact cause of rectal prolapse, but risk factors include chronic constipation, straining to pass bowel motions, and weakened pelvic floor muscles.
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