Abstract

Introduction
Rectal prolapse is a full-thickness protrusion of the rectum through the anal sphincter commonly seen in older people. In young people, rectal prolapse is uncommon. Any condition leading to increased intrabdominal pressure is contributory. This rectal prolapse is always an inconvenience for patient. This paper discusses a case of giant rectal prolapse.

Case report
A case of large rectal prolapse in a 25-year-old male is reported. The patient had a recurrent prolapse and was managed conservatively each time. He had a known case of chronic constipation.

Conclusion
Large rectal prolapse in young people is rare. Chronic constipation is commonly seen in rectal prolapse. Surgery is the treatment.

Introduction
Giant rectal prolapse is a rare entity and its actual incidence is unknown. This prolapse is a full-thickness protrusion of the rectum through the anal sphincter. Chronic constipation is the most common risk factor for rectal prolapse. Often there is an incontinence and always distress associated with it. Most cases of rectal prolapse are mild and may resolve on its own. Symptomatic patients have a difficulty in reduction; substantial incontinence and obstructed defecation are candidates for surgery. Operative repair of rectal prolapse involves abdominal or perineal approaches. This paper reports a case of giant rectal prolapse in a young person.

Case report
A 25-year-old man was presented with irreducible rectal prolapse. The patient had recurrent history of rectal prolapse for the last 7 years which gradually increased day-by-day and it was grade 4. There was associated incontinence seen. General physical examination was normal. Systemic and abdominal examination was normal. Per rectal examination revealed large rectal prolapse protruding with oedema and a thickened wall (Figure 1). The patient was managed conservatively to reduce oedema and was repositioned back. Colonoscopy as well as barium examination were normal. Mesh rectopexy was done. Postoperative period was normal and there was an uneventful follow up for 4 years.

Discussion
Rectal prolapse is a full-thickness protrusion of the rectum through the anal canal. Complete rectal prolapse affects children and the elderly. The peak incidence is after the fifth decade in the adult population with women being more commonly affected, representing 80–90% of patients with rectal prolapse. Rectal prolapse may be seen in pregnancy, bulimia nervosa, combined genital prolapse and rectal prolapsed infantile myofibromatosis and condyloma acuminita or giant villous adenoma of rectum.

A very long and mobile rectum with normal anatomy of perineum is present in young adults with full-thickness rectal prolapse. Abnormal findings commonly observed may be levator ani diastasis, an abnormally deep cul-de-sac, a redundant sigmoid colon, a patulous anal sphincter and loss of the rectal sacral attachments.

Full-thickness prolapse of the rectum causes significant discomfort and is a debilitating condition. Sensation of the prolapse itself, the mucus discharge, and incontinence are seen and are always inconvenient for patient. Constipation, diarrhoea or minor bleeding can occur. Rarely, the prolapsed portion of the rectum can become incarcerated or even strangulated. Young male patients with rectal prolapse have symptoms mostly related to bowel evacuation.

Anal manometry, anal ultrasound, defecography, anal electromyography, pudendal nerve terminal motor latency test, sigmoidoscopy, colonoscopy and magnetic resonance imaging are tests used in evaluation of rectal prolapse. Initially there is a conservative management for rectal prolapse with stool softeners or laxatives and avoidance of prolonged straining. These conservative methods allow reduction of the prolapsed rectum. Oedema may be reduced by the application of sugar, by the injection of Hyaluronidase, or by applying an elastic compression wrap.

Surgery is the treatment of choice in rectal prolapse. Surgical approach to be applied is directed by comorbidities of the patient, the surgeon’s experience, age of patient and bowel function. Abdominal procedures are generally better for young fit patients. Perineal procedures are preferable for patients who are not fit for abdominal procedures, such as elderly frail patients having significant comorbidities. Recurrences are usually

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Figure 1: Showing giant rectal prolapse

more in the perineal approach than in the abdominal one\cite{16}. Operative re-
pairs encompass anal encirclement mucosal resection, perineal pro-
tosigmoidectomy, anterior resection with or without rectopexy, suture 
rectopexy and mesh rectopexy.

Conclusion
Large rectal prolapse in young is rare. Chronic constipation is commonly seen in rectal prolapse. Surgery is the treatment

Consent
Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

References
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