Clinical Case No. 15

50-year-old female

Personal physiological medical history: Nothing remarkable.

Past medical history: negative

Recent medical history

For nearly six months the patient had experienced rectal tenesmus and the sensation of a foreign body in the anus-rectum; episodic constipation, dyschezia; rarely negligible bleeding. The patient believed she was affected by rectal prolapse because, in periods of constipation, during defecation she palpated something mucosal in consistency emerging from the anus. Prescribed suppositories and laxatives did not resolve the condition.

Physical examination

On rectal exploration a nodular, mobile, soft formation was palpable; no other pathological sign was detected. With the patient in a genupectoral position and invited to strain, a multilobed neoformation, approximately 3 cm. in diameter, pink in color, with a peduncle, emerged from the anus.

Double-contrast barium enema (Fig. 1) confirmed the above finding, without other signs of colonic disease.

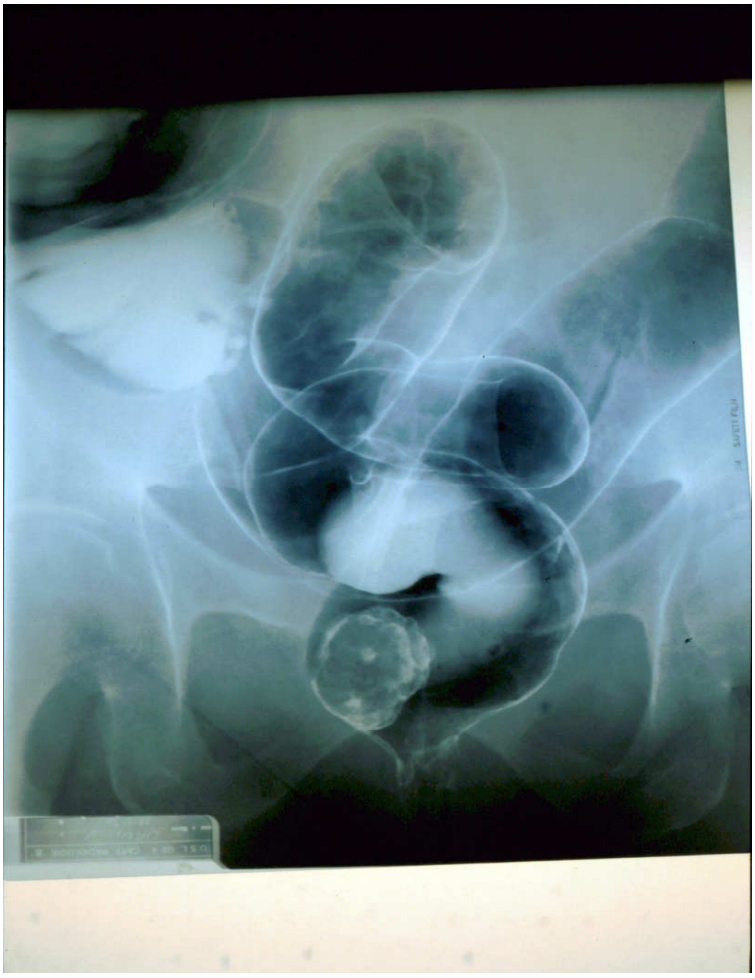

Fig. 1

Colonoscopy specified that it was a polypoid formation, mobile, localized near the dentate line with a short, thin and narrow-based peduncle. This examination, too, revealed no other noteworthy sign of disease.

Given the polyp's distal location, its mobility and its propensity to prolapse, transanal resection was decided.

Operation

Following spinal anesthesia, moderate anal divulsion was performed, which led to the immediate prolapse of the polyp (Fig. 2). The peduncle was easily retrieved, and was interrupted at its base.

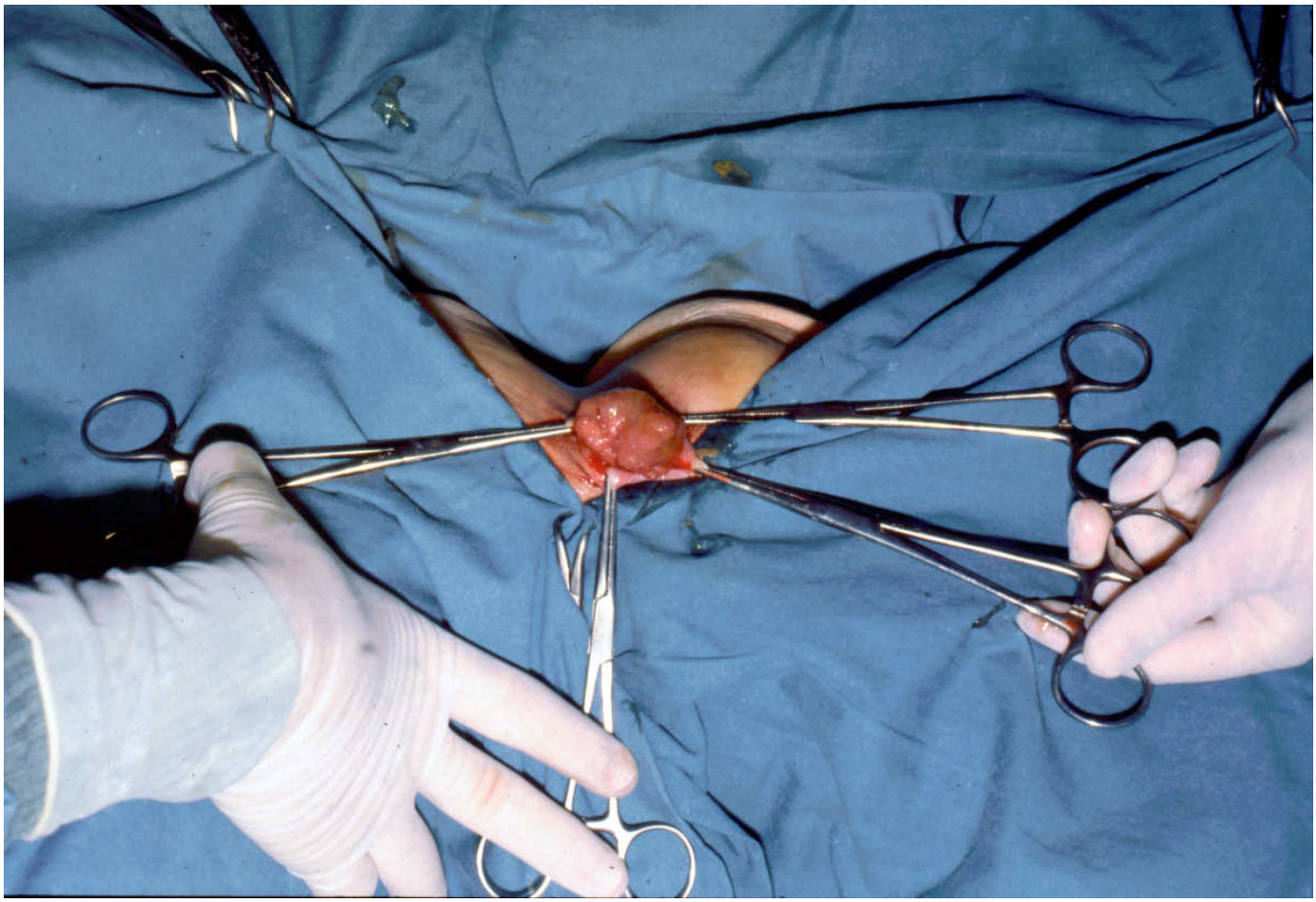

Fig. 2

Histopathology

The general appearance was characterized by glandular structures; the adenomatous epithelium presented mucous production, albeit scarce; the lamina propria was not thickened. No noteworthy findings on the peduncle or its base.

These elements induced the diagnosis of benign tubular adenoma.

No particular findings worthy of mention on immediate and long-term follow-up.

Remarks

We are thus confronted with a pedunculated tubular polyp of the distal rectum which manifested by prolapsing in its near entirety from the anus. By itself, the case would seem somewhat commonplace, were it not for the fact that in our extensive and long-standing surgical experience this was our only observation of anal polyp that spontaneously prolapsed from the anus. Moreover, the disorder seldom finds mention the medical literature. Not surprisingly, therefore, the doctor who was first consulted failed to take this condition into consideration when his patient referred to a presumable rectal prolapse.

Colorectal tubular polyps (tubular adenomas) like villous and mixed types, represent a relatively frequent eventuality and, given the risk of malignant transformation that these lesions harbor, one of significant oncologic importance. The greater the diameter of the polyp, the higher the probability that change will come about. Localization in the rectum is reported in 20% of cases, compared to 40% in the right and 40% in the left colon.

Polypoid neoformations of the rectum, and even more so those of the colon, often evade diagnostic detection because they are asymptomatic in the vast majority of cases. On the other hand, it is now a consolidated fact that colorectal carcinoma arises at a rate of nearly 100% in once benign adenomas, particularly in tubular and tubulovillous forms. A story is told about a small town in Northern Europe where the incidence of colorectal cancer was tragically high. Until one day when someone in the town's government obligated all of the town's citizens to undergo colonoscopy, which revealed a remarkably high percentage of subjects with colorectal polyps. These were removed, and as a consequence the percentage incidence of colorectal cancer fell dramatically.

From this vantage point, the...."theatrical" (in a manner of speaking) manifestation of the polyp in our case was entirely fortunate. After all, a preliminary diagnosis could have been reached by the patient's doctor had he performed a digital rectal exam in his office. Regretfully, far too many general practitioners do not know how or are reluctant to perform this simple and often invaluable diagnostic procedure.

As far as treatment is concerned, we preferred the transanal resection of the polyp given the formation's practically spontaneous revelation of itself and the localization of its pedunculated base near the dentate line. We could have opted to operate under local anesthesia, but it seemed more important to us to guarantee maximum visualization of the distal rectum by means of anal divulsion, and achieving this was preferable through spinal anesthesia, both for the analgesic effect and the optimal muscle relaxation that this approach affords. We disregarded other methods entailing endoscopic tools (e.g., anoscopy, rectoscopy), which we deemed excessively complicated and in this case not very fitting in view of the polyp's distal localization.
