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Rectal Prolapse Management Options and Follow Up in Pediatric

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Abstract

Rectal prolapse in children typically resolves spontaneously or may require manual pressure for reduction. Complete resolution of rectal prolapse can happen spontaneously or within 12 months of conservative management if the underlying causes and precipitating factors are managed adequately the chances of recurrence or persistence of rectal prolapse is about 10% may not respond to conservative management after 12 months and this group of patients will benefit from operative intervention. The aim of this study was to evaluate our experience with managing rectal prolapse in the pediatric age group.

Keywords: Rectal Prolapse; Pediatrics; Non-Operative; Constipation; Sclerotherapy

Introduction

Rectal prolapse is defined as the protrusion of the rectum externally through the anus, either partial or full thickness [1]. Most commonly, rectal prolapse in pediatrics is noticed before the age of four. Children presenting after that age are thought to have a lower success rate with medical management alone, and often require surgical management [2]. Incidence in male and female children is equal. Many factors act as predisposing conditions, the most common of which is chronic constipation and stool withholding, which are most frequently seen during potty training years [3]. Acute infectious diarrheal disease and intestinal parasites are more commonly seen in poor countries [4,5]. Congenital abnormalities associated with abnormal bowel and defecation, such as spina bifida, myelomeningocele, Hirschsprung's disease, anorectal malformation, Ehlers-Danlos syndrome, and cystic fibrosis (CF) also play a major role in increasing the rate of rectal prolapse [2,5]. Children with developmental delay and behavioral/psychiatric disorders present a more difficult challenge, as managing their defecation behaviors requires a multidisciplinary team approach for best outcomes? [6-8].

Methods

A retrospective study of children aged 6 months till 14 years and who were managed for rectal prolapse between January 2020 and December 2024 at the pediatric surgery unit. We did exclude two categories from our study. The First group was Children who had had an intervention for rectal prolapse at peripheral hospitals before referral to our hospital for further treatment, and the second group was those children who were older than 14 years of age. Data was collected from the outpatient clinic records, operation data, and ward admission-discharge records. The extracted data included the age of the child at presentation, sex, duration of prolapse before first hospital visit, any preceding medical condition, intervention performed, and duration of hospital stay and outcomes. The follow-up period was one year. Ethical approval was obtained from the ethics and research committee and informed consent was not taken from the parents due to the retrospective nature of the study. Information was expressed as percentages, median, mean, and range.

Result

A total of 133 cases of rectal prolapse were seen during the study period and form the basis of this report. There were 94 (70.6%) males, 39 (29.4%) females and the median age of the patients was 12 months with a range of 6 months to 5 years. The mean duration the rectal prolapse before presentation to the hospital was 3 days, range 2 to 6 days. The mean duration of hospital stay was 4 days, range from2 to 7 days. Sixty percent (60%) of patients had a preceding history of constipation, while (32%) patients had other factors, including diarrhea, chronic cough, cystic fibrosis, and straining during defecation before the

rectal prolapse occurred. A history of preceding illness could not be obtained in about (8%) patients. All the patients had mucosal (partial) prolapse. All the patients were managed non-operatively. This non-operative treatment consists of manual reduction of the prolapsed rectum and bowel management programs One hundred sixteen (87.2%) patients did not experience any recurrence of the rectal prolapse during the follow up period with a median resolution time of nine months. Seventeen (12.8 %) patients were lost to follow up. None of the patients had operative treatment of the rectal prolapse [9].

Discussion

In our study, males were affected more than females, which is similar to other literature [10,11]. However, some studies reported that both genders are equal in the distribution of rectal prolapse between males and females [12]. The reason for the male predominance in pediatric age remains unknown. The mean age of our patients was 12 months. Studies reported that rectal prolapse is a self-limiting condition in infancy and early childhood, and it is worth subjecting all patients in this age to conservative management. The presentation of the patients to the pediatric emergency room was delayed, which is demonstrated in the mean interval of three days before presentation to the hospital [13,14]. None of the patients came within the first 48 hours of the onset of the prolapse this is because of Lack of caregivers' awareness, which may explain the delayed presentation. The mean duration of hospital stay of four days, which was the time required for the reduced rectal mucosa to adhere to the rectal submucosa, and the rectal prolapse resolved. While sixty percent of the patients in our series had a preceding history of constipation just before to the onset of the rectal prolapse, other factors, including diarrhea, chronic cough, cystic fibrosis, and straining during defecation, affected the remaining patients before the appearance of rectal prolapse. This is consistent with the data of other reports on pediatric rectal prolapse [6,15,16], also constipation has been documented as a risk factor for rectal prolapse in adult patients [17].

All our patients had mucosal prolapse, as in pediatric age, mucosal prolapse is more common than complete prolapse. The increased incidence of mucosal prolapse in pediatric patients may be due to poor fixation of the mucosal layer to underlying submucosa. [2,15] The presence of multiple circular folds on the prolapsed mucosa and multiple thickness of the prolapsed rectum on palpation in complete rectal prolapse can differentiate it from the mucosal prolapse [8,9]. As reported by other studies that treatment of rectal prolapse is mainly conservative and is directed at managing the underlying condition factors, such as constipation with dietary modification, diarrheal parasitic infestations treatment, better toilet training methods, and biofeedback training. All patients in the current series were treated conservatively with a period of one year follow-up in the outpatient clinic. Operative treatment of rectal prolapse is reserved for resistant or recurrent cases [5,10]. Non-operative management of rectal prolapse starts with spontaneous or manual reduction of the prolapsed rectum. Although Spontaneous reduction of prolapsed rectum is common, manual reduction of prolapsed rectum may be required at home, or in the pediatric emergency room, as Prolonged prolapse may result in a more edematous rectum and more difficult reduction. [4,7] Applying a steady, sustained pressure to reduce the prolapsed rectum into the anus with a well-lubricated gloved hand, and a finger centered at the rectum to direct the reduction. After reduction, temporary gluteal muscle taping is used to prevent immediate recurrence.

The aim of non-operative management of rectal prolapse is to treat underlying medical conditions. After exclusion of infectious or developmental abnormalities, the most appropriate protocol is a bowel management program that provides an extensive modality for treating constipation and promoting healthy defecation hygiene. [9,12] Although bowel management programs have many forms throughout the world, common instructions include adequate water and fiber intake, regular toileting habits, and laxative therapy. Toileting habits aiming to reduce time and straining during defecation. Patients are asked to spend no more than five minutes at a time on the bathroom and to alleviate distractions such as mobile phones during defecation. Proper anatomical positioning will reduce straining with the adjunct use of a step stool. Common stool softeners such as Polyethylene glycol also promote proper defecation. Duration of medical management is also not standardized before next steps are considered; however, a 2019 American Pediatric Surgery Association survey study reporting practice patterns amongst North American providers reported that 47.9% of providers would trial medical management for three to six months, while 28.1% of providers would continue medical management up to one year [18].

Sclerotherapy injection may be considered in refractory cases after an adequate trial of medical treatment. Ethanol and 5% phenol have been the most commonly used agents. The treatments could be effective, but complications from the agents have also been reported. [7,10] Other studies report alternative safe agents such as 15% hypertonic saline, 50% dextrose, and Defluxbut still not widely used. Limited Perianal interventions have been used as an alternative to sclerotherapy. Such as anal circlage and Rectosacropexy. [3,7] Perineal surgery, like posterior sagittal rectopexy and perineal proctectomy/ proctosigmoidectomy, was also mentioned as treatment for disease refractory to local therapy. These are less invasive compared to transabdominal rectopexy, but have higher recurrence rates. [9,16] The most frequently performed surgery after failed local therapy is rectopexy, either open or Laparoscopic are both commonly performed with good outcomes, and recently robotic approach shows similar outcomes.

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Meanwhile, sigmoidectomy accompanying transabdominal rectopexy appears to be the best choice for recurrent prolapse after surgical intervention [15,16].

Conclusion

Rectal prolapse in pediatric age is commonly seen problem .Non operative management is highly effective in most patients particularly with accompanying bowel management programs and addressing underlying medical conditions, Duration of medical management is still not standardized before next steps are considered but six to nine months would be accepted, for medically refractory cases, and in children with developmental disorders, Sclerotherapy and rectopexy are effective options preferred by most surgeons.

Ethics Approval and Consent to Participate

The study has a retrospective nature and was conducted ethically.

Consent for Publication

A written informed consent to publish this information was obtained from the parents of the child.

Authors' contributions

Mohamed Gaber: conception of the all work, data collection analysis and interpretation, drafting the article.

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