SUMMARY AND CONCLUSIONS

Defaecation is the process of eliminating solid or semi-solid waste from the digestive tract via the anus. The rectum is approximately 15 cm long, joins the sigmoid colon at the rectosigmoid flexure and ends at the anal canal, which is about 1.5–3 cm in anal sphincter length.

The rectum is a storage area for the solid waste to be eliminated from the body. The anal canal and anus only open during defaecation and are kept closed at all other times by the internal and external anal sphincter muscles. The internal anal sphincter is under autonomic nervous system, involuntary control, while the external anal sphincter is under voluntary control.

The present essay aims to discuss the etiology, diagnosis and management of solitary rectal ulcer with emphasis on the recent trends in this important issue.

The term SRUS probably is a misnomer, because ulcers are only found in 40% of patients, while 20% of patients have a solitary ulcer, and the rest of the lesions vary in shape and size, from hyperemic mucosa to broad-based polypoid lesions. There is even a suggestion that the disease process also may involve the sigmoid colon.

The underlying cause for this type of ulceration is chronic local ischemia of the colonic wall. Although the gradual sequence of this pathology may originate for various reasons, SRUS has been related to several independent clinical settings.

Rectal intussusception, which may lead to full-thickness rectal prolapse, results in localized vascular trauma and ischemia, initiating solitary local ulceration.

Uncoordinated sequence of muscle contraction and relaxation required for the defecation process, also called puborectalis syndrome or pelvic outlet obstruction, causes

increased pressure inside the rectum and anal canal, generating ischemia and ulceration.

Localized rectal trauma, mainly from digitation or self-instrumentation, has been proposed as one of the causes of SRUS.

The characteristic histologic features include fibrous obliteration of the lamina propria; disorientation and thickening of the muscularis mucosa; and regenerative changes, with distortion of the crypt architecture.

Up to 26.0 % of patients can be asymptomatic, discovered incidentally while investigating other diseases. The average time from the onset of symptoms to diagnosis, in one study, ranged from 3 months to 30 years (mean, 5 years) with similar results in different series.

SRUS is a disorder of young adults, occurring most commonly in the third decade in men and in the fourth decade in women. It, however, has been described in

children and in the geriatric population. Men and women are affected equally, with a small predominance for women.

Patients usually present with passage of mucus and blood per rectum on defecation. The amount of blood varies from slight fresh blood to severe hemorrhage that requires blood transfusion. Other complaints are tenesmus, straining, altered bowel habits, incontinence, and a sensation of incomplete evacuation. A polypoid mass may protrude at the anal orifice.

In children, a recent study reported that rectal bleeding was the presenting feature in all the children. Mucorrhea, constipation, tenesmus and rectal prolapse were observed in 77.3%, 63.6%, 59% and 13.6% children.

The endoscopic spectrum of SRUS may vary from simple hyperemic mucosa to small or giant ulcers to broad-based polypoid lesions in different sizes and number. Macroscopically, SRU typically appear as shallow ulcerating lesions on a hyperemic surrounding mucosa, most often located on the anterior wall of the rectum at 5 to 10 cm from

the anal verge. Ulcers may range from 0.5 to 4 cm in diameter but usually are 1 to 1.5 cm in diameter.

Because of the wide endoscopic spectrum of SRUS and the fact that the condition may go unrecognized or, more commonly, misdiagnosed, it is crucial to take biopsy specimens from the involved area to make a positive confirmation of the diagnosis and to exclude other diagnoses, including cancer.

Defecography is very useful at identifying the presence of internal or external mucosal prolapse or intussusception in SRUS. Defecography also can demonstrate a hidden prolapse, as well as a nonrelaxing puborectalis muscle and incomplete or delayed rectal emptying.

Barium enema may show rectal stricture, granularity of the mucosa, and thickened rectal folds, all of which are nonspecific.

Transrectal US is useful to distinguish SRUS from other conditions, e.g., invasive cancer. An inhomogeneous