



Bladder & Bowel Community

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Fact Sheet: Bowel Prolapse

Rectal prolapse is when part of your rectum (back passage), or the lining of your rectum, protrudes through your anus. The rectum is the last 20 cm or so of the large bowel and is the temporary storage area for bowel motions.

Types of rectal prolapse

There are three main types of rectal prolapse.

- Full-thickness rectal prolapse is when part of the wall of your rectum protrudes through your anus.
- Mucosal prolapse is when the lining of your rectum protrudes through your anus.
- Internal intussusception rectal prolapse is when your rectum folds in on itself but doesn't protrude through your anus.

Rectal prolapse mainly affects women – it's most common in women aged over 50, however, it can happen at any age. It can also affect men and young children under three.

Symptoms of rectal prolapse

You may first notice the protrusion when you're having a bowel movement, but it can also happen when you cough or sneeze, lifting or even when you're doing everyday activities, such as walking or standing up.

The symptoms of rectal prolapse can be similar to those of haemorrhoids. The most obvious being a lump or swelling coming out of your anus, but you may also experience;

- Pain during bowel movements.
- Mucus or blood discharge from the protruding tissue.
- Faecal incontinence.
- Constipation.
- Awareness of something protruding upon wiping.

Initially you may only have a protrusion when you have a bowel movement which retracts or reduces spontaneously afterwards. However, as the condition develops it may also happen when you cough or stand up. Eventually, the protruding rectum may need to be manually replaced by a finger or it may continually protrude.

If you have internal intussusception rectal prolapse, there may be no lump or swelling coming through your anus. However, you may feel as though something is still in your rectum after you empty your bowels.

Causes of rectal prolapse

It's not fully understood why rectal prolapse develops. It's often associated with weakened pelvic floor muscles which are a group of muscles that form a supporting sling between your pubic bone and the base of your spine, and certain conditions that put extra pressure on your abdomen, such as:

- Pregnancy.
- Menopausal changes.
- Weakened pelvic floor muscles.
- Constipation and/or straining when you have a bowel movement.
- Diarrhoea.
- Conditions that cause you to cough a lot, such as cystic fibrosis, chronic obstructive pulmonary disease (COPD) or whooping cough, asthma cough or smokers cough.
- Rectal prolapse is also occasionally related to neurological conditions, including: multiple sclerosis (MS), lumbar disc disease, an injury to your lower back or pelvis, spinal tumours.

In older women, rectal prolapse can occur at the same time as a prolapsed womb or bladder. This is thought to be due to a general weakness in your pelvic floor muscles, which may be related to previous pregnancy and childbirth. For more information on the pelvic floor muscles please read our Pelvic Floor Muscle Exercises fact sheet, available on our website and from our office.

Diagnosis of rectal prolapse

Your GP will ask about your symptoms and may examine you by inserting a gloved finger inside your rectum. Your GP may be able to diagnose a rectal prolapse following his examination. They may then consider referring you to a Colo-rectal Surgeon, who specialises in conditions that affect the bowel for further tests.

These tests may include:

- Evacuation proctography –this is a type of X-ray or scan that shows your rectum and anal canal when you're having a bowel movement.
- Sigmoidoscopy – this uses a thin tube with a light and camera at the end to allow a doctor to look at the inside of your rectum and lower part of your bowel.
- Colonoscopy – this uses a narrow, flexible, tube-like telescopic camera called a colonoscope to allow a doctor to look higher inside your large bowel.
- Endoanal ultrasound- this uses a thin ultrasound probe to look at the muscles used for bowel control.
- Transit study – a test to determine whether or not movement through the bowel is normal or slow in cases where there is a history of constipation.

- Ano-rectal physiology - These tests are designed to measure the strength of the muscles around your anus and rectum and the sensation inside your anus and rectum.

You may also need to have other tests to rule out any underlying conditions that may be causing your rectum to prolapse.

Treatment for rectal prolapse

In the early stages of your condition, your doctor may advise you to eat plenty of fruit and vegetables and other foods that contain fibre to try to prevent constipation and reduce straining.. If you have difficulty increasing your dietary fibre they may suggest you take bulking or osmotic laxatives, such as Fybogel, Movicol to help you empty your bowels without straining. Your doctor will also advise you to drink plenty of water, about 1.5-2 litres a day.

In children, rectal prolapse usually gets better without any treatment. Your GP will give you advice on how to get your child into a regular bowel routine. Ensure your child has plenty of fruit and vegetables in their diet, as well as foods that contain fibre. Also ensure your child drinks enough water. Your GP will also advise you on how to push your child's rectum back into their anus when it prolapses.

Occasionally, your doctor may recommend your child has an injection of a substance called a sclerosant to help destroy the prolapsed tissue or surgery. However, this is only considered if other treatments have not been successful. It will also depend on how old your child is and how serious their condition is.

Surgery

Generally there are two approaches to surgery; the perineal and abdominal approach. The choice of surgery depends on many factors including age, other health issues, presence of incontinence, surgeon preference and the size of the prolapse. Your surgeon will advise you on the best type of operation for you.

Perineal approach - The rectal prolapse can be pulled out through the anal canal and operated on from below.

Abdominal approach - By operating from within the abdomen the rectum can be hitched up to prevent it prolapsing down. Abdominal approaches can be carried out either through conventional open wounds or by laparoscopic (keyhole) surgery. The rectum is fixed with either sutures or mesh. Occasionally, it may be planned to remove part of the colon as well.

It's important to remember that the rectal prolapse may come back after you have surgery by either method. The likelihood of a successful operation will depend on the type of surgery you have and your individual circumstances. It is important therefore to continue to reduce straining after having surgery

Following surgery normal activities can be resumed after 2 weeks but heavy lifting should be avoided for 6 weeks. It is important to avoid constipation and stool softeners and pain killers are usually given at discharge from hospital.

Minor problems such as a wound infection, bruising and difficulty in passing urine can occur post-operatively but are easily treatable. In some instances there can be a long-term change of bowel habit following surgery either going more frequently or developing constipation. Medications can be given to help in both cases.

Further information

You may wish to seek advice from your local continence clinic. The continence clinics are run by the NHS and you don't always need to be referred to a clinic by your GP, as some clinics will allow you to book an appointment yourself. To find your nearest continence clinic please call our office on 01926 357220.

The Bladder and Bowel Community provides information and support for people with bladder and bowel issues. We publish a wide range of user-friendly booklets and factsheets.

For more information please call us on 01926 357220, email help@bladderandbowel.org or write to us at The Bladder and Bowel Community, 7 The Court, Holywell Business Park, Northfield Road, Southam, CV47 0FS.

www.bladderandbowel.org

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