Rectal prolapse (bulge from anus)

A Practical Guide For Patients

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Introduction: Rectal prolapse (bulge from anus)

Rectal prolapse occurs when the rectum—the final part of the large intestine—loses its normal support and moves downward. In an external rectal prolapse, rectal tissue extends through the anus and appears as a reddish or pink bulge outside the body. Complete prolapse involves the full thickness of the rectal wall, while partial or mucosal prolapse involves only the inner lining. An internal prolapse may remain inside the body and may not be visible.

Early in the condition, the bulge may appear only during a bowel movement and then go back inside on its own. As prolapse progresses, it may need to be manually pushed back or may remain outside the anus. Some patients describe the sensation as feeling as though they are “sitting on a ball.”

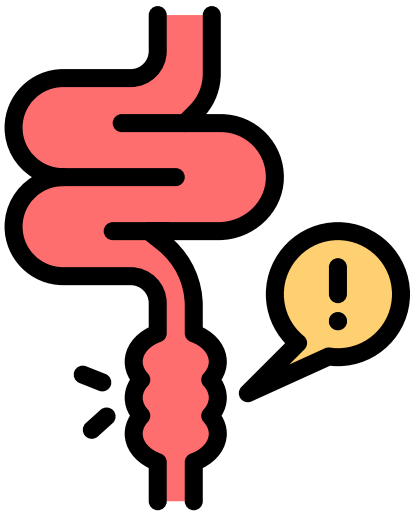
Key Takeaways

- Rectal prolapse occurs when part or all of the rectum drops downward and may protrude through the anus.
- The most recognizable symptom is a red or pink bulge from the anus.
- The prolapse may initially appear only during bowel movements.
- It may return inside spontaneously in earlier stages.
- Progressive prolapse may need to be manually pushed back.
- Constipation and excessive straining are common associated factors.
- Chronic diarrhea can also contribute.
- Rectal prolapse may cause mucus leakage, bleeding, constipation, and fecal incontinence.

What Causes Rectal prolapse (bulge from anus)

Known Causes:

- **Chronic constipation:** Long-standing constipation is frequently associated with rectal prolapse.
- **Repeated straining:** Excessive pressure during bowel movements can contribute to weakening of rectal and pelvic support.
- **Chronic diarrhea:** Frequent diarrhea is another recognized risk factor.
- **Pelvic-floor weakness:** Weak pelvic-floor muscles provide less support to the rectum.
- **Weak anal sphincter muscles:** Rectal prolapse commonly occurs with weakened sphincter function.
- **Abnormally mobile rectum:** Loss or weakness of the normal attachments holding the rectum in position may allow it to descend.
- **Pelvic surgery:** Previous surgery may sometimes affect tissues or nerves supporting the pelvic floor.
- **Neurologic or pelvic-floor disorders:** Disorders affecting the nerves or supporting tissues may increase susceptibility.



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Common Signs & Symptoms

Rectal prolapse often develops gradually. At first, tissue may protrude only while straining for a bowel movement and then retract spontaneously. Over time, the prolapse may occur more easily—even with standing or routine activity—and may require manual reduction.

Core Symptoms Include:

- **Bulge from the anus:** A red or reddish-pink mass protrudes from the anal opening.
- **Prolapse during bowel movements:** Tissue may initially appear only while passing stool.
- **Feeling of incomplete evacuation:** The rectum may feel as though it has not emptied completely.
- **Fecal leakage:** Stool may seep unexpectedly.

Severe cases can also cause:

- A prolapse that remains outside continuously
- Difficulty manually returning the rectum inside
- Increasing bleeding
- Ulceration of exposed rectal tissue
- Significant mucus or fluid leakage
- Progressive fecal incontinence
- Increasing difficulty passing stool
- Swelling of the prolapsed tissue

Diagnosis & Medical Testing

Rectal prolapse is frequently diagnosed through a combination of the medical history and direct examination. A clinician will ask about the appearance of the bulge, bowel habits, constipation, straining, stool leakage, urinary symptoms, and other pelvic-floor problems.

Diagnostic Tools:

- **Medical history:** Reviews when the bulge appears, whether it returns inside, constipation, diarrhea, straining, bleeding, mucus, and fecal leakage.
- **Anorectal examination:** Allows direct assessment of the anus and prolapsed tissue.
- **Digital rectal examination:** Assesses rectal anatomy, sphincter tone, and other abnormalities.
- **Straining examination:** The patient may be asked to bear down to reproduce the prolapse.
- **Defecography:** X-ray or MRI imaging records the rectum and pelvic organs during simulated defecation.
- **MR defecography:** Provides dynamic imaging of the rectum and other pelvic-floor structures.
- **Anorectal manometry:** Measures anal and rectal muscle pressure, function, and reflexes.
- **Colonic transit testing:** May be useful when severe or lifelong constipation accompanies prolapse.
- **Colonoscopy:** May be performed before treatment to evaluate the colon and exclude associated polyps, cancer, inflammation.

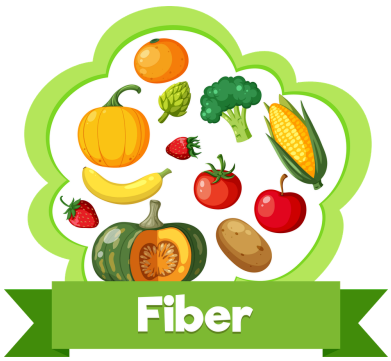
Diet

Diet cannot pull an already prolapsed rectum back into its normal anatomical position. However, maintaining soft, regular bowel movements and reducing straining can help minimize symptoms and is particularly important before and after treatment.

Key Insights:

- Eat adequate dietary fiber when constipation is present and no contraindication exists.
- Include fruits, vegetables, legumes, whole grains, and other tolerated fiber sources.
- Increase fiber gradually rather than suddenly.
- Avoid repeated straining during bowel movements.
- Do not ignore the urge to defecate for long periods.
- Avoid prolonged sitting and pushing on the toilet.
- Address chronic diarrhea rather than assuming more fiber will solve every bowel problem.
- Use individualized bowel-management strategies if both constipation and fecal leakage occur.







Medications & Treatment Options

There is no medication that permanently repairs an adult full-thickness rectal prolapse. Medicines are primarily used to manage constipation, diarrhea, or other bowel problems that contribute to straining and symptom progression. Definitive correction of persistent adult rectal prolapse generally requires surgery.

Treatment Options

- **Fiber supplements:** May help produce softer, more regular stool when constipation is present.
- **Stool softeners:** Can reduce the need to strain.
- **Osmotic laxatives:** May be considered for constipation under medical guidance.
- **Short-term mild laxatives:** May sometimes be used after surgical repair.
- **Diarrhea treatment:** Appropriate treatment may be needed when chronic loose stools contribute to prolapse.
- **Bowel-regimen optimization:** Regular bowel movements with minimal straining are an important supportive goal.
- **Pelvic-floor management:** Associated pelvic-floor dysfunction may require evaluation and additional treatment.
- **Skin protection:** Barrier products may sometimes help when mucus or stool leakage irritates the surrounding skin.
- **Surgical referral:** Persistent or full-thickness prolapse generally requires evaluation by a colon and rectal surgeon.

Advanced Therapies & Procedures

Surgery is the definitive treatment for most adults with symptomatic full-thickness rectal prolapse. Broadly, surgical repair can be performed through the abdomen or through the perineum, and the choice depends on the prolapse, bowel function, age, overall health, previous operations, and surgical risk.

Therapy Options:

- **Abdominal rectopexy:** The rectum is returned to its normal position and secured to structures in the pelvis, usually the sacrum.
- **Laparoscopic rectopexy:** Rectopexy is performed through small abdominal incisions.
- **Robotic rectopexy:** A robotic-assisted minimally invasive approach may be used in selected patients.
- **Resection rectopexy:** Part of the colon may be removed along with rectal fixation in selected patients, particularly when significant constipation is present.
- **Mesh-assisted rectopexy:** Some rectopexy techniques use mesh to reinforce or support the rectum.
- **Perineal rectosigmoidectomy (Altemeier procedure):** The prolapsed rectum is removed through the perineal approach and the remaining bowel is reconnected.
- **Combined pelvic-floor repair:** When significant vaginal, bladder, uterine, or other pelvic-organ prolapse coexists, coordinated treatment may sometimes be appropriate.

Coping With Rectal prolapse (bulge from anus)

Rectal prolapse can be physically uncomfortable and can also affect confidence, daily activities, travel, exercise, bowel routines, and willingness to leave home. Mucus leakage or fecal incontinence may create additional practical difficulties.

Practical Strategies

- Keep bowel movements soft and regular.
- Avoid repeated straining.
- Avoid sitting on the toilet for unnecessarily long periods.
- Maintain adequate dietary fiber when appropriate.
- Maintain adequate hydration.
- Treat persistent constipation.
- Seek assessment for chronic diarrhea.
- Note when the prolapse occurs.
- Record whether it returns inside by itself.
- Note whether it must be manually reduced.
- Record bleeding or mucus leakage.
- Monitor stool or gas leakage.
- Note increasing difficulty with bowel evacuation.
- Keep the surrounding skin clean and dry when mucus or stool leakage occurs.
- Discuss urinary, vaginal, or other pelvic-floor symptoms with the clinician.



FAQS

Q1: What does rectal prolapse look like?
A: External rectal prolapse typically appears as a reddish or pink mass protruding through the anus. It may initially appear only during a bowel movement and return inside afterward. As the condition progresses, it may remain outside or need to be manually pushed back.

Q2: How can I tell rectal prolapse from hemorrhoids?
A: Both can cause tissue to protrude from the anus and may bleed, but they are different conditions. Rectal prolapse involves the rectum telescoping downward, while hemorrhoids involve swollen vascular tissue in or near the anal canal.

Q3: Can rectal prolapse heal without surgery?
A: In adults, bowel-management changes can reduce constipation and straining but generally do not correct an established full-thickness rectal prolapse. ASCRS describes surgery as the definitive treatment for adult rectal prolapse. In children, treatment is different and often begins by correcting the underlying cause such as constipation or diarrhea.

Q4: When is rectal prolapse an emergency?
A: Seek urgent medical attention if the prolapsed rectum cannot be pushed back inside, becomes increasingly swollen or severely painful, changes to a dark or abnormal color, or causes heavy bleeding.

Take Action

A recurrent bulge or mass coming through the anus, particularly during bowel movements, should be medically evaluated rather than automatically assumed to be hemorrhoids. Rectal prolapse can gradually worsen and may contribute to constipation, mucus leakage, bleeding, and loss of bowel control.

For additional resources, visit **GastroDoxs.com**.

Your health starts with knowledge. Take the first step today!

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