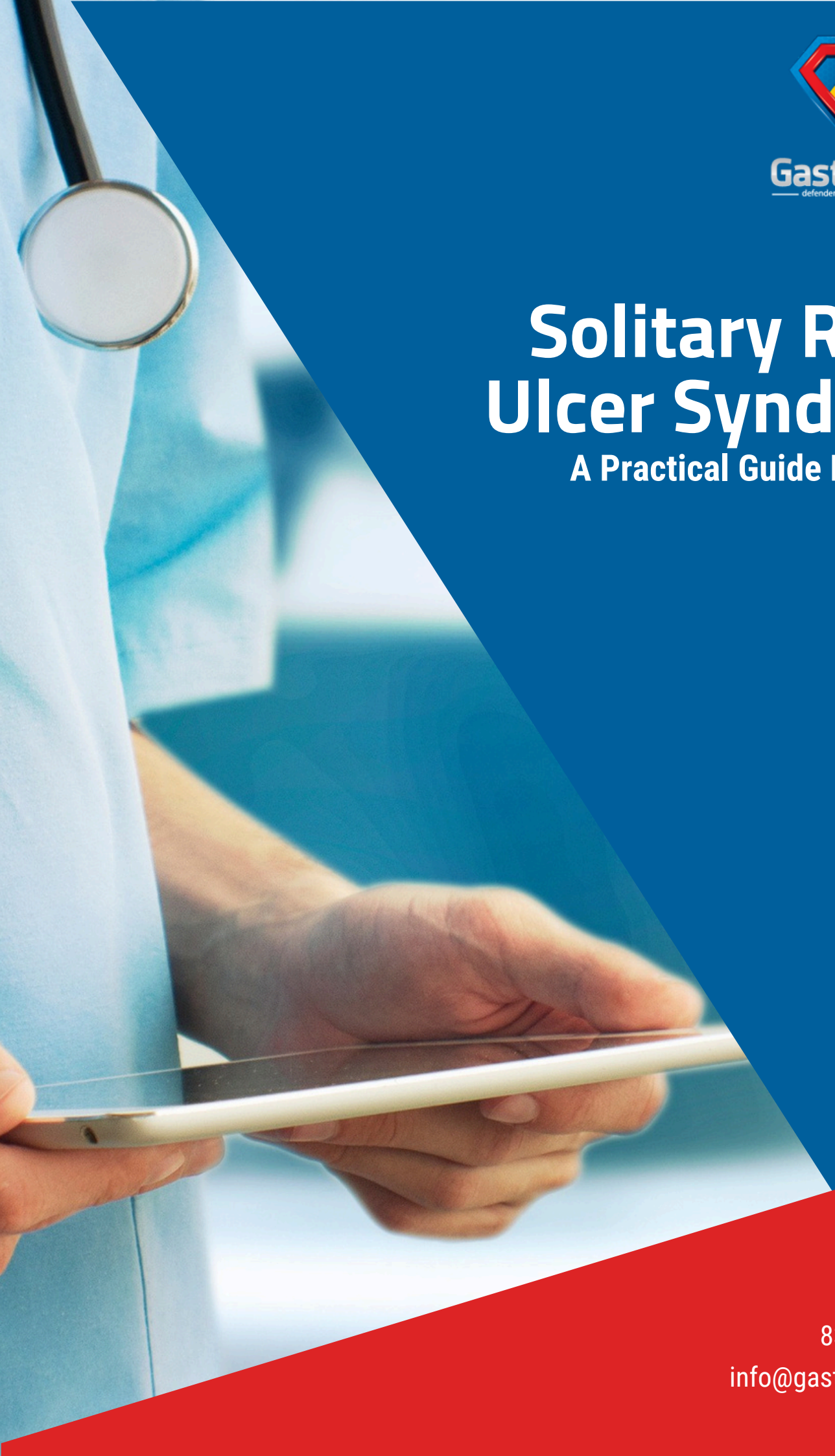


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Solitary Rectal Ulcer Syndrome

A Practical Guide For Patients

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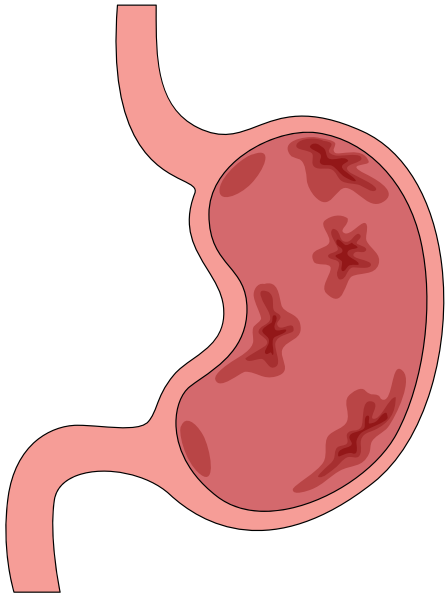
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Introduction: Solitary Rectal Ulcer Syndrome

Solitary rectal ulcer syndrome, also called SRUS, is an uncommon, noncancerous disorder affecting the rectum. It develops when repeated pressure, straining, abnormal pelvic floor coordination, or rectal prolapse damages the rectal lining. The condition may appear as a single ulcer, multiple ulcers, red inflamed tissue, or a raised polyp-like lesion.



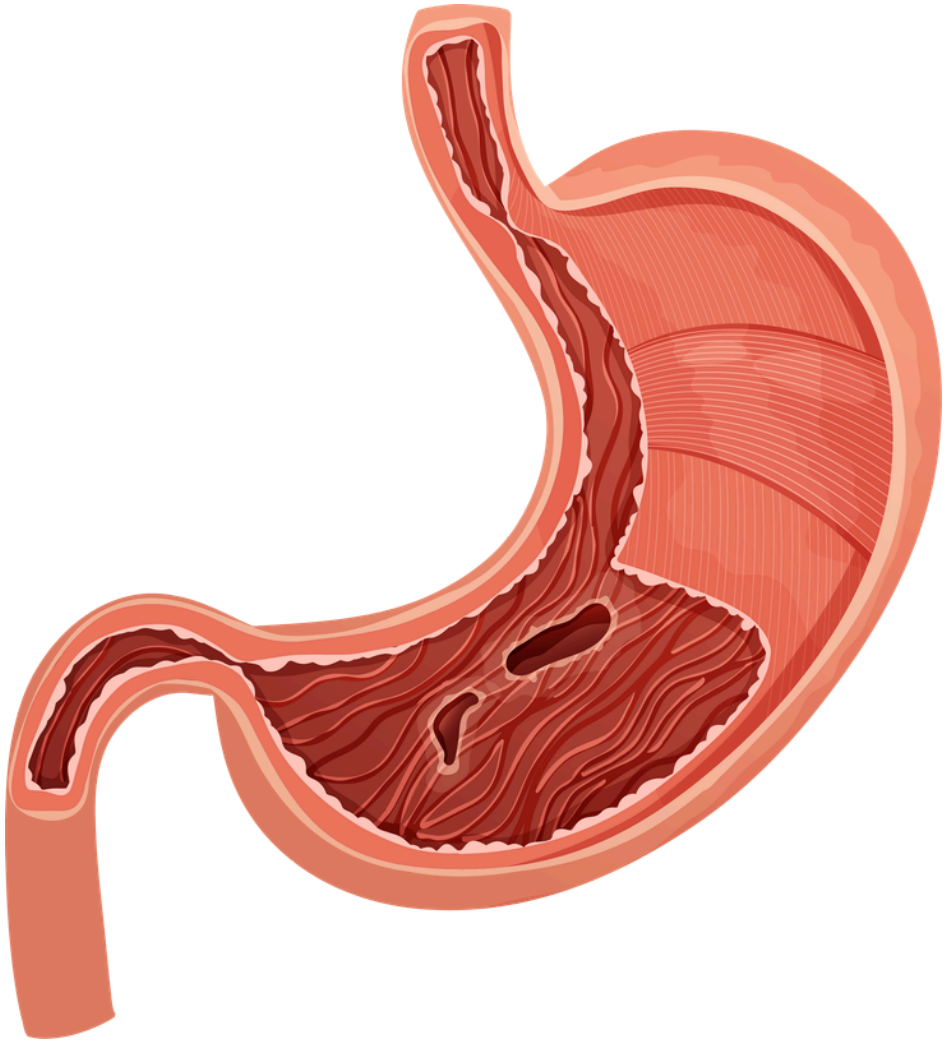
Key Takeaways

- SRUS is a chronic, benign condition affecting the rectal lining.
- It is not a form of cancer.
- The condition may occur with or without a visible ulcer.
- Some patients have several ulcers rather than one.
- Rectal bleeding and mucus discharge are common symptoms.
- Constipation and excessive straining frequently contribute.
- Abnormal pelvic floor coordination may prevent complete evacuation.
- Internal or external rectal prolapse may repeatedly injure the rectum.
- Colonoscopy or sigmoidoscopy helps identify the affected tissue.
- Biopsy is important because SRUS can resemble other rectal diseases.
- Fiber, hydration, bowel retraining, and biofeedback may improve symptoms.

What Causes Solitary Rectal Ulcer Syndrome?

Known Causes

SRUS usually results from repeated trauma and reduced blood flow to the rectal lining. Excessive straining, abnormal pelvic floor contraction, rectal prolapse, and attempts to remove stool manually can place pressure on the rectal wall. Over time, this may cause inflammation, ulceration, bleeding, and scar-like tissue changes.



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Common Signs & Symptoms

Symptoms often develop gradually and may continue for months or years before diagnosis. Rectal bleeding may be mild and appear on toilet paper, or it may be mixed with stool. Some patients have mucus discharge, rectal pressure, and repeated unsuccessful attempts to empty the bowel.

Core Symptoms Include:



- Bright red rectal bleeding
- Blood on toilet paper or stool
- Mucus discharge from the rectum
- Constipation
- Excessive straining
- Rectal pain or discomfort
- Lower abdominal cramping
- Feeling that the bowel has not emptied

Severe cases can also cause:



- Persistent or increasing rectal bleeding
- Iron-deficiency anemia
- Significant rectal pain
- Ulcer enlargement or deeper tissue injury
- Severe constipation or stool impaction
- Prolapsed tissue that cannot be returned

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Diagnosis & Medical Testing

Diagnosis requires evaluation of symptoms, bowel habits, pelvic floor function, and the rectal lining. Because SRUS can resemble inflammatory bowel disease, infection, polyps, and rectal cancer, tissue biopsy is essential for confirming the diagnosis and excluding other conditions.

Diagnostic Tools

- **Digital rectal examination:** Assesses rectal tenderness, masses, stool, muscle tone, and pelvic floor function.
- **Anoscopy:** Examines the anal canal and lowest portion of the rectum.
- **Flexible sigmoidoscopy:** Directly examines the rectum and lower colon.
- **Colonoscopy:** Evaluates the entire colon when bleeding or another disease must be excluded.
- **Rectal biopsy:** Confirms characteristic microscopic tissue changes.
- **Pathology review:** May identify fibromuscular changes, crypt distortion, and thickened muscular tissue.
- **Complete blood count:** Checks for anemia caused by ongoing bleeding.

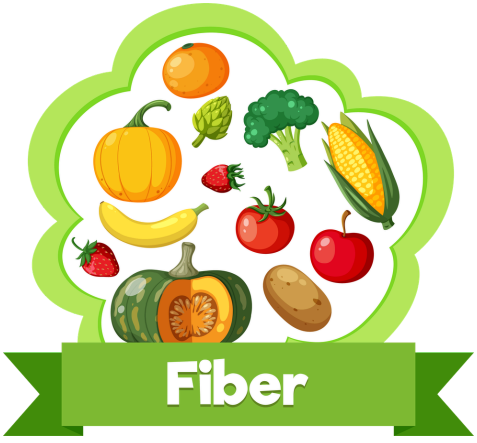


Diet

Diet cannot directly heal SRUS when prolapse or pelvic floor dysfunction continues. However, adequate fiber and hydration may soften stool, reduce straining, and prevent repeated injury. Dietary recommendations should be adjusted when severe constipation, narrowing, bloating, or another digestive condition is present.

Key Insights

- Increase dietary fiber gradually.
- Include vegetables, fruits, beans, lentils, and whole grains.
- Choose soluble fiber when coarse fiber increases bloating.
- Drink adequate water throughout the day.
- Eat meals at regular times to encourage predictable bowel movements.
- Avoid skipping meals when it worsens constipation.
- Include adequate calories and protein to support tissue healing.
- Limit highly processed foods that are low in fiber.
- Reduce foods that repeatedly worsen constipation.
- Avoid excessive dairy products if they contribute to hard stools.
- Limit alcohol when it causes dehydration.





Medications & Treatment Options

Treatment is selected according to symptom severity, bowel habits, pelvic floor function, and whether rectal prolapse is present. Mild disease may improve with bowel-habit changes and constipation treatment. Persistent disease may require topical therapy, biofeedback, or surgical correction of prolapse.

Treatment Options

- **Fiber supplementation:** Helps produce softer, more formed stools.
- **Osmotic laxatives:** Draw water into the bowel and may reduce straining.
- **Stool softeners:** Make hard stool easier to pass.
- **Constipation medication:** Prescription therapy may be considered when standard measures are insufficient.
- **Topical sucralfate:** May be given as an enema to coat and protect the ulcerated rectal lining.
- **Topical corticosteroids:** May reduce local inflammation in selected patients.
- **Topical mesalamine:** May be used to control rectal inflammation in some cases.
- **Bulk-forming agents:** May improve stool consistency and bowel regularity.
- **Pain management:** Relieves discomfort while avoiding medicines that worsen constipation when possible.

Advanced Therapies & Procedures

Advanced treatment is considered when symptoms continue despite bowel retraining and medical therapy or when significant rectal prolapse is present. The procedure should address the underlying mechanical problem rather than the ulcer alone.

Therapy Options

- **Pelvic floor biofeedback therapy:** Retrains defecation and reduces inappropriate straining.
- **Physical therapy:** Improves pelvic floor coordination and bowel-emptying techniques.
- **Repeat sigmoidoscopy:** Reassesses healing or persistent rectal lesions.
- **Repeat biopsy:** May be required when the appearance changes or the diagnosis remains uncertain.
- **Endoscopic bleeding treatment:** Controls selected areas of active rectal bleeding.
- **Rectopexy:** Secures the rectum in its normal position to treat internal or external prolapse.
- **Laparoscopic rectopexy:** Uses minimally invasive surgery to repair rectal prolapse.
- **Ventral mesh rectopexy:** Supports the front of the rectum in selected patients with prolapse.
- **Delorme procedure:** Removes part of the prolapsed rectal lining and tightens the muscle wall.
- **Altemeier procedure:** Removes the prolapsed rectal segment through a perineal approach.

Coping With Solitary Rectal Ulcer Syndrome

Living with SRUS may be frustrating because symptoms can recur and bowel movements may require considerable time or effort. Improvement often depends on changing long-established toilet habits and consistently practicing pelvic floor techniques. Patients should avoid repeated trauma to the rectum and report ongoing bleeding rather than assuming it is harmless.

Practical Strategies

- Follow a regular daily bowel routine.
- Respond to the natural urge to have a bowel movement.
- Avoid forcing a bowel movement when no urge is present.
- Limit the amount of time spent sitting on the toilet.
- Avoid excessive straining.
- Use a footstool to improve toilet posture when recommended.
- Practice pelvic floor exercises taught by a therapist.
- Avoid manual stool removal whenever possible.
- Take fiber and laxatives exactly as directed.
- Maintain adequate fluid intake.
- Keep a diary of bleeding, mucus, pain, and bowel movements.
- Monitor stool consistency and frequency.
- Attend all gastroenterology and pelvic floor therapy appointments.
- Complete recommended follow-up endoscopy.
- Report increasing bleeding or unexplained fatigue.

FAQS About
Solitary Rectal Ulcer Syndrome



Q1: What is solitary rectal ulcer syndrome?
A: Solitary rectal ulcer syndrome is a benign disorder caused by repeated injury to the rectal lining. It is commonly associated with constipation, excessive straining, pelvic floor dysfunction, or rectal prolapse. Despite its name, there may be several ulcers or no visible ulcer.

Q2: What causes solitary rectal ulcer syndrome?
A: Common causes include chronic constipation, forceful straining, pelvic floor dyssynergia, internal rectal prolapse, rectal intussusception, prolonged toilet sitting, and manual removal of stool. These factors can reduce blood flow and repeatedly injure the rectal lining.

Q3: How is solitary rectal ulcer syndrome diagnosed?
A: Diagnosis usually involves a medical history, rectal examination, flexible sigmoidoscopy or colonoscopy, and tissue biopsy. Defecography, anorectal manometry, balloon-expulsion testing, and other pelvic floor tests may identify prolapse or abnormal defecation.

Q4: How is solitary rectal ulcer syndrome treated?
A: Treatment may include fiber, fluids, constipation medication, avoidance of straining, pelvic floor biofeedback, and topical rectal therapy. Surgery may be needed when significant rectal prolapse is present or symptoms continue despite conservative treatment.

Take Action

If you experience recurring rectal bleeding, mucus discharge, constipation, rectal pain, prolonged straining, or a persistent feeling of incomplete evacuation, do not ignore the symptoms. Proper examination and biopsy can distinguish SRUS from inflammatory bowel disease, polyps, rectal prolapse, and rectal cancer.

Visit **GastroDoxs.com** to schedule an appointment and access more resources on digestive health.



Your health matters
take the next step
today!

SCHEDULE AN APPOINTMENT

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