

# Rectal Polyp Prolapse: A Case Report

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## Abstract

Colorectal adenomas are polyps that develop from the mucosa and exhibit neoplastic characteristics. Adenomas' increasing dysplasia and malignant potential are connected to their size, villous content, and patient's age. An anorectal emergency is definitely a possibility when there are large villous polyps in the rectum. They could be involved in rectal bleeding, blockage, prolapse, or imprisonment. We describe a 53-year-old female who was treated successfully for giant tubulovillous rectal adenoma that was prolapsed through anal opening. The patient's clinical symptoms and signs were mistaken for prolapsed hemorrhoids.

**Keywords:** Rectal polyp- Tubulo-villous- Villous- Trans anal excision

*Asian Pac J Cancer Biol*, **8** (4), 407-408

Submission Date: 07/15/2023

Acceptance Date: 09/27/2023

## Introduction

Histologically, colorectal polyps can be classed as neoplastic (which can be benign or malignant), adenomatous (including serrated adenomatous) or non-neoplastic (including hyperplastic, mucosal, inflammatory and hamartomatous) polyps. By the ages of 50 and 70, the general population is affected by adenomatous polyps in around 33% and 50%, respectively, of the population. A single adenoma is present in 60% of cases, whereas numerous lesions are present in 40% of cases. The majority of lesions are less than 1 cm in size. Lesions will be found 60% of the time distal to the splenic flexure [1]. In an emergency situation, prolapsing anorectal polyps can mimic benign anorectal diseases like prolapsed hemorrhoids and provide treatment challenges.

### Case Report

A 53-year-old female patient was admitted to our emergency department with a mass protruding from the anal canal. She had a prolapsing rectal mass approximately for two years, although she always refused further colonoscopic evaluation or surgical treatment since the mass was relocated spontaneously. On admission, she did not refer to abdominal pain or diarrhea. She mentioned chronic constipation and rarely the urgency of defecation. Physical examination did not reveal abdominal pain or signs of intestinal obstruction. There were no symptoms of intestinal obstruction or

abdominal discomfort upon physical examination. A prolapsed mass with a diameter of 7 cm that was discovered during rectal examination while the patient was in the lithotomy posture (Figure 1). The bulk had a rotting surface, erosion, and a bad odor. The other biochemical readings were normal, and the hemoglobin level was 7.6 g/dL. Under general anesthesia, the polyp that was protruding from the anal canal was removed via transanal excision. By transanally excising the bulk and underlying muscle layer in one piece, clean surgical margins were achieved. There were no difficulties after the operation. The pathologic evaluation of the tumor revealed that it was a tubulovillous adenoma with intramucosal carcinoma. No lymphovascular invasion was seen, and the tumor was low-grade and well-to-moderately differentiated. No further treatment was recommended.

## Discussion

There are polyps in each part of the colon. Adenomatous polyps can have one of three basic histologic subtypes: tubular, villous, or tubulovillous. The World Health Organization defines tubular adenomas as having less than 25% villous component, 25-75% tubulovillous component, and greater than 75% villous component [2]. The most frequent types of adenomas are tubular, tubulovillous, and villous. There are equal numbers of

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Figure 1. A Prolapsed Mass with a Diameter of 7 cm

tubular adenomas throughout the colon. The rectum is a preferred location for villous adenomas. They could be asymptomatic or connected to bleeding, blockage, electrolyte imbalance, mucous excretion, or diarrhea [2,3]. Villous adenomas have a chance of 35–40%, tubulovillous adenomas of 20–25%, and tubular adenomas of 5% [4].

The management of polyps should be based on the size and shape of the polyps, which are two critical characteristics that may indicate the presence of underlying malignancy. They might be sessile (typically tubulovillous or villous), pedunculated (typically tubular or tubulovillous), or non-polypoid (flat or depressed). Only 1.3% of small adenomas (less than 1 cm) are malignant, whereas 46% of adenomas larger than 2 cm are. On complete removal of the polyp, malignant cells are discovered in 5.7%, 18%, and 34.5% of adenomatous polyps with mild, moderate, and severe dysplasia, respectively [1]. According to the United States National Polyp Study, an advanced adenoma is one that is less than one centimeter in size or contains invasive malignancy or high-grade dysplasia. It has repeatedly been demonstrated that a negative resection margin is linked to a lower likelihood of unfavorable outcomes (recurrence, residual carcinoma, lymph node metastases, and shorter survival). The pathologic analysis revealed that the polyp in our patient was a tubulovillous polyp with intramucosal carcinoma in the polyp head and was excised with a negative resection margin. The stem of the polyp was not invaded. Polyps that prolapse through the anus are associated by a number of different ways. Since there is less fat in the ischioanal fossa during the earliest years of life, less pressure is applied to this essential part of the perineum, it appears that this condition is more common in children [5-7]. Adults are most susceptible to prolapse when their anal sphincter is damaged or dysfunctional or when they have illnesses like chronic constipation that raise intra-abdominal pressure [8]. In our case, the patient experienced constipation but no obvious changes in the integrity of the anal sphincter that would lead to prolapse. Treatment options for prolapsed polyps include conservative treatment, endoscopic resection, and even ultralow anterior excision, albeit there is no universally accepted method [9]. Nearly all pedunculated polyps can be removed safely and effectively using colonoscopic polypectomy. Finally, screening and surveillance programs are advised since people with anorectal adenomatous

polyps have a known higher risk of developing cancer. If the entire polyp was removed without partial removal, patients with 3-10 adenomas, any adenoma less than 1 cm, any adenoma with villous features, or high-grade dysplasia should have their next colonoscopy in 3 years [10,11].

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