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 ow-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
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].

References


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