Rectal prolapse occurs when the rectum (the last section of the large intestine) falls from its normal position within the pelvic area. (The word “prolapse” means a falling down or slipping of a body part from its usual position.)

The term “rectal prolapse” can describe three types of prolapse:

- The entire rectum extends out of the anus
- Only a portion of the rectal lining is pushed through the anus
- The rectum starts to drop down but does not extend out the anus (internal prolapse)

Rectal prolapse is common in older adults with a long-term history of constipation or a weakness in the pelvic floor muscles. It is more common in women than in men and even more common in women over the age of 50 (postmenopausal women) but occurs in younger people too. Rectal prolapse can also occur in infants – which could be a sign of cystic fibrosis – and in older children.

The symptoms of rectal prolapse include the feeling of a bulge or the appearance of reddish-colored mass that extends outside the anus. At first, this can occur during or after bowel movements and is a temporary condition. However, over time – due to an ordinary amount of standing and walking – the end of the rectum may extend out of the anal canal and needs to be pushed back up into the anus by hand.

Other symptoms of rectal prolapse include pain in the anus and rectum and rectal bleeding from the inner lining of the rectum. These are rarely life-threatening symptoms. Fecal incontinence is another symptom. Fecal incontinence refers to leakage of mucus, blood or stool from the anus.
This occurs as a result of the rectum stretching the anal muscle. Symptoms change as the rectal prolapse itself progresses.

**What causes rectal prolapse?**

Rectal prolapse can occur as a result of many conditions, including:

- **Chronic constipation or chronic diarrhea.**
- **Long-term history of straining during bowel movements.**
- **Older age.** Muscles and ligaments in the rectum and anus naturally weaken with age. Other nearby structures in the pelvis area also loosen with age, which adds to the general weakness in that area of the body.
- **Weakening of the anal sphincter.** This is the specific muscle that controls the release of stool from the rectum.
- **Prior injury to the anal or pelvic areas.**
- **Damage to nerves.** If the nerves that control the ability of the rectum and anus muscles to contract are damaged, rectal prolapse can result. Nerve damage can be caused by pregnancy, difficult vaginal childbirth, anal sphincter paralysis, spinal injury, back injury/back surgery, and/or other surgeries of the pelvic area.
- **Other diseases, conditions, and infections.** Rectal prolapse can be a consequence of diabetes, cystic fibrosis, chronic obstructive pulmonary disease, hysterectomy, and infections in the intestines caused by parasites – such as pinworms and whipworms – and diseases resulting from poor nutrition or from difficulty digesting foods.

**Is rectal prolapse just another name for hemorrhoids?**

No. Rectal prolapse results from a sagging of the last portion of the large intestine. Hemorrhoids are swollen blood vessels that develop in the anus and lower rectum. Hemorrhoids can produce anal itching and pain, discomfort, and bright red blood on toilet tissue. Early rectal prolapse can mimic internal hemorrhoids that have slipped out of the anus (ie, prolapsed), making it difficult to tell these two conditions apart.

**How is rectal prolapse diagnosed?**

First, your doctor will take your medical history and will perform a rectal exam. You may be asked to “strain” while sitting on a commode to mimic an actual bowel movement. Being able to see the prolapse helps your doctor confirm the diagnosis and plan treatment.

Other conditions are could be present along with rectal prolapse such as urinary incontinence, bladder prolapse and vaginal/uterine prolapse. Because of the variety of potential problems, urologists, urogynecologists and other specialists are often team together to share evaluations and make joint treatment decisions. In this way, surgeries to repair any combination of these problems can be done at the same time.

There are several tests doctors can use to diagnose rectal prolapse and other pelvic floor problems. Tests used to evaluate and make treatment decisions include:

- **Anal electromyography (EMG):** This test determines if nerve damage is the reason why the anal sphincters are not working properly. It also examines the coordination between the rectum and anal muscles.
● **Anal manometry:** This test studies the strength of the anal sphincter muscles. A short, thin tube, inserted up into the anus and rectum, is used to measure the sphincter tightness.

● **Anal ultrasound:** This test helps evaluate the shape and structure of the anal sphincter muscles and surrounding tissue. In this test, a small probe is inserted up into the anus and rectum to take images of the sphincters.

● **Pudendal nerve terminal motor latency test:** This test measures the function of the pudendal nerves, which are involved in bowel control.

● **Proctography (also called defecography):** This test is done in the radiology department. In this test, an X-ray video is taken that shows how well the rectum is functioning. The video shows how much stool the rectum can hold, how well the rectum holds the stool, and how well the rectum releases the stool.

● **Colonoscopy:** This is an exam of the colon or large bowel. A flexible tube with a camera is passed through the anus upwards to where the large intestine joins the small intestine. This helps provide visual clues as to the source of the problem.

● **Proctosigmoidoscopy:** This test allows the lining of the lower portion of the colon to be viewed, looking for any abnormalities -- such as inflammation, tumor, or scar tissue. To perform this test, a flexible tube with a camera attached at the end is inserted into the rectum up to the sigmoid colon.

● **Magnetic resonance imaging (MRI):** This test is done in the radiology department. It is sometimes used to evaluate the pelvic organs.

**How is rectal prolapse treated?**

In some cases of very minor, early prolapse, treatment can begin at home with the use of stool softeners and by pushing the fallen tissue back up into the anus by hand. However, surgery is usually necessary to repair the prolapse. There are several surgical approaches. The surgeon’s choice depends on patient’s age, other existing health problems, the extent of the prolapse, results of the exam and other tests, and the surgeon’s preference and experience with certain techniques.

Abdominal and rectal (also called perineal) surgery are the two most common approaches to rectal prolapse repair.

**Abdominal Repair Approaches**

Abdominal procedure refers to making an incision in the abdominal muscles to view and operate in the abdominal cavity. It is usually performed under general anesthesia and is the approach most often used in healthy adults. The two most common types of abdominal repair are rectopexy (fixation [reattachment] of the rectum) and resection (removal of a segment of intestine) followed by rectopexy. Resection is preferred for patients with severe constipation. Rectopexy can also be performed laparoscopically through small key-hole incisions or robotically.

**Rectal (Perineal) Repair Approaches**

Rectal procedures are often used in older patients and in patients with more medical problem. Spinal anesthesia or an epidural may be used instead of general anesthesia in these patients. The two most common rectal approaches are the Altemeier and Delorme procedures.

- **Altemeier procedure.** In this procedure, also called a perineal proctosigmoidectomy, the portion of the rectum extending out of the anus is cut off (amputated) and the two ends are sewn back together. The remaining structures that help support the rectum are stitched back together in an attempt to provide better support.

- **Delorme procedure.** In this procedure, only the inner lining of the fallen rectum is removed. The outer layer is then folded and stitched and the cut
edges of the inner lining are stitched together so that rectum is now inside of the anal canal.

What are the risks/complications that may occur after surgery?

As with any surgery, anesthesia complications, bleeding, and infection are always risks. Other risks and complications from surgeries to repair prolapse include:

- Lack of healing where the two ends of bowel reconnect (this can happen in a surgery in which a segment of the bowel is removed and the two ends of the remaining bowel are reconnected)
- Intraabdominal or rectal bleeding
- Urinary retention (inability to pass urine)
- Medical complications of surgery: heart attack, pneumonia, deep venous thrombosis (blood clots)
- Return of rectal prolapse
- Worsening or development fecal incontinence
- Worsening or development of constipation

After surgery, constipation and straining should be avoided. Fiber, fluids, stool softeners, and mild laxatives can be used.

How successful is surgery?

Success can vary depending on the condition of supporting tissues and the age and health of the patient. Abdominal procedures are associated with a lower chance of the prolapse reoccurring compared with perineal procedures. However, in most patients, surgery fixes the prolapse.

How long is recovery?

The average length of hospital stay is three to five days but this varies depending on a patient’s other existing health conditions. Complete recovery can usually be expected in three months; however, patients should avoid straining and heavy lifting for at least six months. In fact, the best chance for preventing prolapse from recurring is to make a lifetime effort to avoid straining and any activities that increase abdominal pressure.

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