



Rectal Polyp Prolapse: Clinical Image

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Abstract

Colorectal polyp designates any well circumscribed sessile or pedicled formation, of variable size, ranging from a few millimeters to a few centimeters, protruding into the lumen of the colon or rectum without prejudging its histological nature. A three-year-old female child presented with a small, fleshy, necrotic, slightly bleeding mass through the anus. A ligation was performed before polypectomy.

Post-operative sigmoidoscopy was unremarkable.

Polyp in children can be complicated by a prolapse through the anus. Excisional biopsy allows a precise histological diagnosis from which the appropriate course of therapy and follow-up can be determined.

Keywords: Polyp; Child; Excisional biopsy

Clinical Image

A three-year-old female child was admitted for a prolapse through the anus. She had a long history of moderate abundance rectorrhagia. These rectorrhagia are generally recurrent and minimal, associated with discrete abdominal pain such as cramps and diarrhea with muco-purulent emissions.

Clinical examination revealed a small, fleshy, necrotic and slightly bleeding anal protuberance (Figure 1,2).

Digital rectal examination found the implantation pedicle on the anal mucosa. The stalk was ligated completely then polypectomy was performed with no operating complications. Post-operative sigmoidoscopy was unremarkable.

The real frequency of polyps in children remains difficult to evaluate because many of them remain asymptomatic. They are exceptional before the age of one year and become more frequent after two years, reaching a maximum frequency between the ages of four and eight [1].

The most common symptom observed in mild hematochezia. Its quick resolution explains why sometimes the child or his family attaches little importance to this symptom, which explains its chronic evolution [2].

Rectal examination is carried out with the little finger or index finger depending on the age of the child. It allows the recognition of polyps less than 10 cm away, in the form of a more or less rounded mass, consistency, volume, and mobility and above all sessile or pedicle implantation (a notion which is often clearer to the touch than to the eye and is essential for assessing the removal methods). The polyp is felt as a firm, elastic mass, which can be mobilized on the rectal wall without the finger being able to impose great movements on it. Rectal examination may be defective when the polyp is too soft or too high or when it remains hidden behind a faecal impaction [3].

The use of endoscopic techniques in children has significantly improved the development, treatment, and statistical data of some conditions of the child's gastrointestinal tract. An essential diagnostic tool, it also allows therapeutic procedures to be performed: Polypectomy, biopsy of a suspicious lesion, etc [4].

The preferred site of the polyps is the rectosigmoid; however, no colonic segment is spared. Thus, a large proportion of polyps are not detected by sigmoidoscopy, again underlining the need for a total colonoscopy in all children with rectal bleeding not explained by anal injury. Polyps are quite often solitary, and cases of multiple polyps can be found in the same patient, not to mention

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Figure 1: Polyp prolaps.



Figure 2: Polyp prolaps.

polyposis [5].

Polyps are most often pedicled; they may be sessile with a broad base of implantation. Both aspects can be found in the same patient with several polyps [6].

Endoscopic polypectomy, a technique widely used in adults, has been possible in children for a decade [7].

However, there are still two sets of arguments in favor of surgical polypectomy: A technical argument about the number and spread of polyps in the colonic environment, which requires long and repeated endoscopic sessions, and the size of certain polyps (3 cm and more in diameter), which makes it difficult and illusory to perform a correct endoscopic removal, exposing the patient to hemorrhages and complications. The other argument is of a carcinological nature, as surgical polypectomy ensures greater carcinological safety [8]. Juvenile polyps are the most common histological type of recto colic polyps [9].

References

1. Bourlière-Najeau B, Tavan A, Gorincour G. Pathologie tumorale intestinale de l'enfant. EMC- Radiologie et imagerie médicale - abdominale-digestive. 2009;33:490-C10.
2. Wei C, Dayong W, Liqun J, Xiaoman W, Yu W, Xiaohong Q. Colorectal polyps in children: A retrospective study of clinical features and the value of ultrasonography in their diagnosis. *J Pedia Surg.* 2012;47(10):1853-8.
3. Pariente A. Adénomes colorectaux. *Encycl Méd Chir - AKOS Encyclopédie Pratique de Médecine.* 2002;4-0520:3.
4. Rodesch P, Cadranel S. Polypes et polypectomies chez l'enfant. *Acta Endoscopica.* 1984;14(5):303-8.
5. Mandhan P. Juvenile colorectal polyps in children: Experience in Pakistan. *Pediatr Surg Int.* 2004;20(5):339-42.
6. Benhamou PH, Dupont C. Diagnosis of digestive hemorrhages in infants and children. *EMC- Emergency Medicine.* 2007;25-140-F-20.
7. Munck A, Mougnot JF, Olschwang S. Polypes et polyposes des enfants. *EMC - Pédiatrie - Maladies infectieuses.* 1998;4-018-Y-20.
8. Church J, Simmong C. Practice parameters for the treatment of patients with dominant inherited colorectal cancer (FAP and hereditary non polyposis colorectal cancer). *Dis Colon Rectum.* 2003;46(8):1001-12.
9. Hood B, Bigler S, Bishop P. Juvenile polyps and juvenile polyp syndromes in children: A clinical and endoscopic survey. *Clin Pediatr (Phila).* 2011;50(10):910-5.