

ENDOSCOPIC SPOT

A rare cause of rectal ulceration

Úlcera rectal de etiologia rara

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Introduction

Prostate cancer is the most common neoplasm affecting men, with an estimated 4,000 new cases diagnosed each year in Portugal.¹ Currently, curative treatment options for men with localized prostate cancer include radical prostatectomy, external beam radiotherapy (EBRT) and prostate brachytherapy (BT) with permanent interstitial implants. This later modality is being increasingly used because it provides similar disease control with lower rates of incontinence and sexual dysfunction. However, it can lead to chronic radiation proctitis, because of the close proximity between the rectum and the implanted prostate.² The main manifestations of chronic radiation proctitis are rectal bleeding, urgency, pain, strictures, mucous discharge and incontinence and they may take up to two years to develop. The association of BT with EBRT raises the incidence of proctitis from 1–19% to 39%.³

Treatment options include medical therapy (aminosalicylates, sucralfate, steroid enemas and hyperbaric oxygen), endoscopic therapy preferably with argon plasma coagulation (safer, less expensive and more widely available than heater and bipolar cautery, Nd:YAG laser and topical

formalin) and surgery in cases of rectal strictures, fistula or in others not amenable to treatment with the previous options.

Rectal ulcers and fistula rarely occur (0.3–5.4%) but are the most feared complications of chronic radiation proctitis. Radiation dose administered to the rectal mucosa, the association with EBRT, previous transurethral resection of the prostate, diabetes, hypertension and inflammatory bowel disease are all risk factors.⁴ It has been shown that rectal ulcers have a favorable response to hyperbaric oxygen therapy with a partial or complete remission in at least half of the patients.⁵

Case description

The patient was a 59-year-old man, with a history of diabetes, and a prostate tumor formerly submitted to external beam radiation and brachytherapy. After six months of post therapy he developed tenesmus, rectal bleeding and pain that required daily analgesia for relief. In more than one occasion, he also needed to be transfused with blood units as an outpatient.

An initial diagnostic colonoscopy was performed, that revealed a small anterior rectal ulcer and scattered angiectasias in the distal 20 cm of the colon (Fig. 1). Treatment with mesalamine enemas was prescribed and argon plasma

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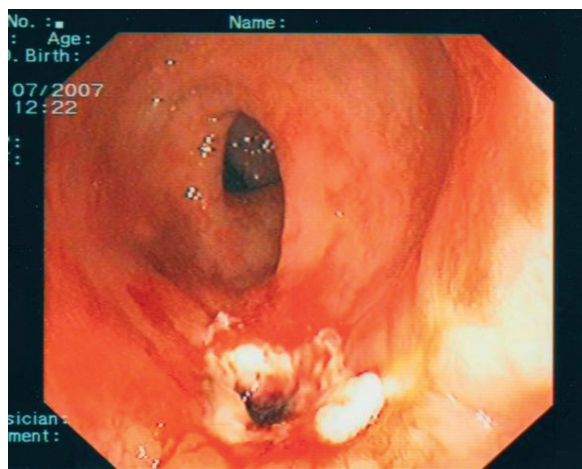


Figure 1 Small anterior rectal ulcer and scattered rectal angiectasias, as seen in the initial endoscopy.

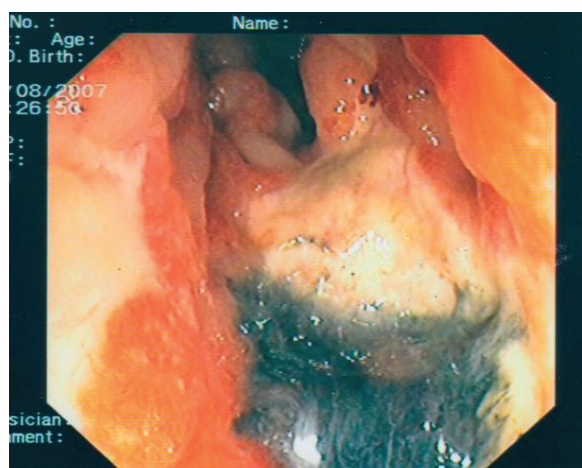


Figure 2 Endoscopy two months later showing progression of the rectal ulcer, in spite of topical treatment.

coagulation was subsequently performed in the bleeding lesions.

Follow-up endoscopies, two (Fig. 2) and four months later (Fig. 3), showed progressive resolution of the bleeding lesions, with both instituted treatments but no significant healing of the ulcer. In fact, it increased in size and became gradually deeper and wider with a necrotic base. At this time, the patient was referred to hyperbaric oxygen therapy that also proved ineffective.

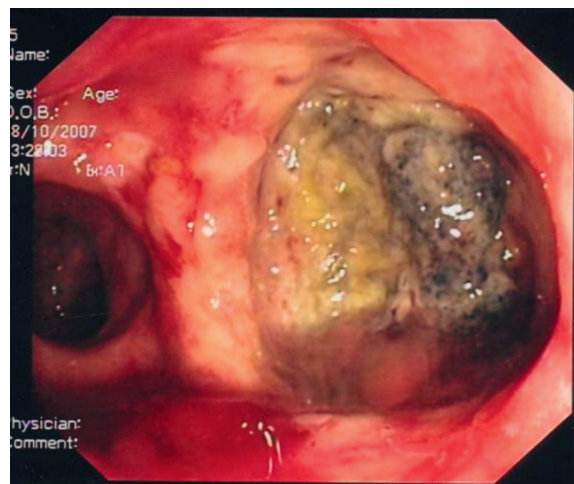


Figure 3 Large anterior rectal ulcer with a wide necrotic base, seen four months after the initial endoscopy.

Later on, he developed a rectovesical fistula that required an abdominoperineal resection of the rectum and the excision of the bladder and prostate.

Conflicts of interest

The authors have no conflicts of interest to declare.

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