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Case Report

Solitary Rectal Ulcer Diagnosed in a Malignancy-Mimicking Polypoid Rectal Lesion: A Case Report

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Abstract

Solitary rectal ulcer syndrome (SRUS) is a chronic anorectal disorder of unknown etiology, most commonly observed in young adults. The diagnosis is established through a combination of clinical, endoscopic, and histopathological findings. Its polypoid appearance, which may mimic malignancy, often leads to misdiagnosis. Herein, we present the case of a 64-year-old woman with a history of constipation and digital evacuation, who was found to have a polypoid rectal lesion resembling malignancy, which was subsequently diagnosed as SRUS.
Keywords: Biofeedback, mesalazine, polypoid rectal lesion, solitary rectal ulcer.

INTRODUCTION

Solitary rectal ulcer syndrome (SRUS) is an uncommon anorectal condition with an incompletely understood pathogenesis, predominantly affecting young adults. Clinical manifestations are often nonspecific and include rectal bleeding, mucous discharge, defecatory difficulty, tenesmus, a sensation of incomplete evacuation, and anorectal pain. Endoscopically, SRUS may present as a single ulcer, a polypoid mass, or erythematous mucosal patches, potentially being mistaken for malignancy.[1-3] Diagnosis is based on a high index of suspicion, endoscopic appearance, and confirmatory histopathology. We report a case of SRUS presenting with a malignancy-mimicking polypoid rectal lesion.

CASE PRESENTATION

A 64-year-old woman presented to the gastroenterology outpatient clinic with a one-year history of constipation, a sensation of incomplete evacuation after defecation, and occasional hematochezia. Her medical history was unremarkable. Upon further inquiry, she reported long-standing use of digital maneuvers to aid evacuation due to constipation.

Flexible sigmoidoscopy revealed a 3-cm ulcerovegetant polypoid lesion on the anterior wall of the rectum, located 5 cm from the anal verge, along with several smaller polyps, the largest measuring 0.5 cm (Figure 1). Multiple biopsies were obtained under suspicion of malignancy. Histopathologic examination revealed chronic inflammatory changes characterized by mononuclear cell infiltration of the lamina propria, ulceration, and inflammatory granulation tissue, with no evidence of malignancy. Pelvic magnetic resonance imaging showed no evidence of a mass lesion (Figures 2-3).

Anorectal manometry demonstrated findings consistent with rectoanal dyssynergia. Based on these findings, a diagnosis of SRUS was established. The patient was instructed in daily biofeedback therapy and advised to discontinue digital evacuation. Topical mesalazine suppositories (1 g/day) were prescribed. At a three-month follow-up colonoscopy, the lesion had regressed significantly, leaving only erythematous mucosal patches and superficial ulcerations (Figure 4). Her defecatory symptoms had also improved markedly.

Written informed consent was obtained from the patient for this case. No artificial intelligence–assisted technologies were used in the preparation of this work.

DISCUSSION

SRUS is a rare but diagnostically challenging chronic condition.[3,4] Its nonspecific clinical features can mimic both benign and malignant disorders. In our case, the endoscopic appearance initially raised suspicion of malignancy, which was subsequently excluded by histopathology in favor of SRUS. Literature reports indicate that SRUS can present with ulcerative, polypoid, or erythematous mucosal patterns.[3]

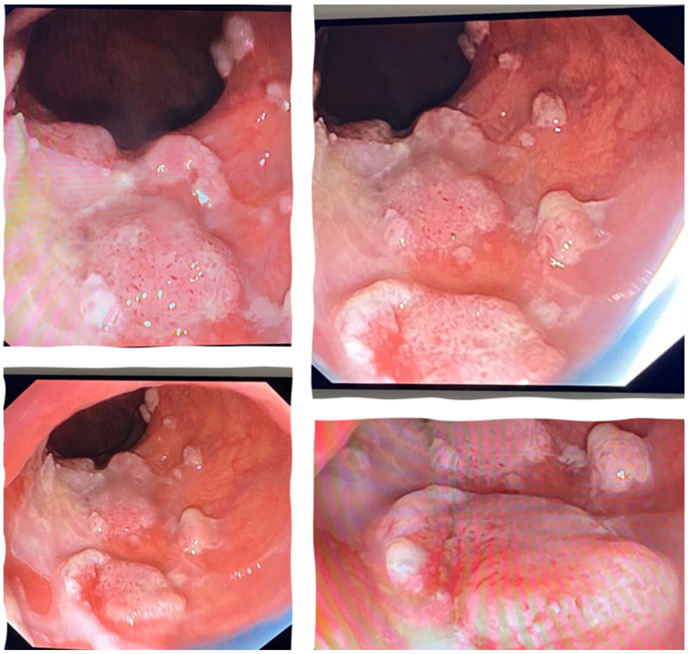

Figure 1. Polypoid ulcerovegetant lesion measuring approximately 3 cm, located on the anterior wall of the rectum, 5 cm from the anal verge, with additional smaller polyps—the largest measuring 0.5 cm.

Figure 2. Thickening of the rectal wall, with the lesion located posteriorly and displaying a mildly polypoid intraluminal configuration. No evidence of diffuse inflammatory changes or infiltration into the surrounding fat tissue is observed, which is not suggestive of malignant infiltration.

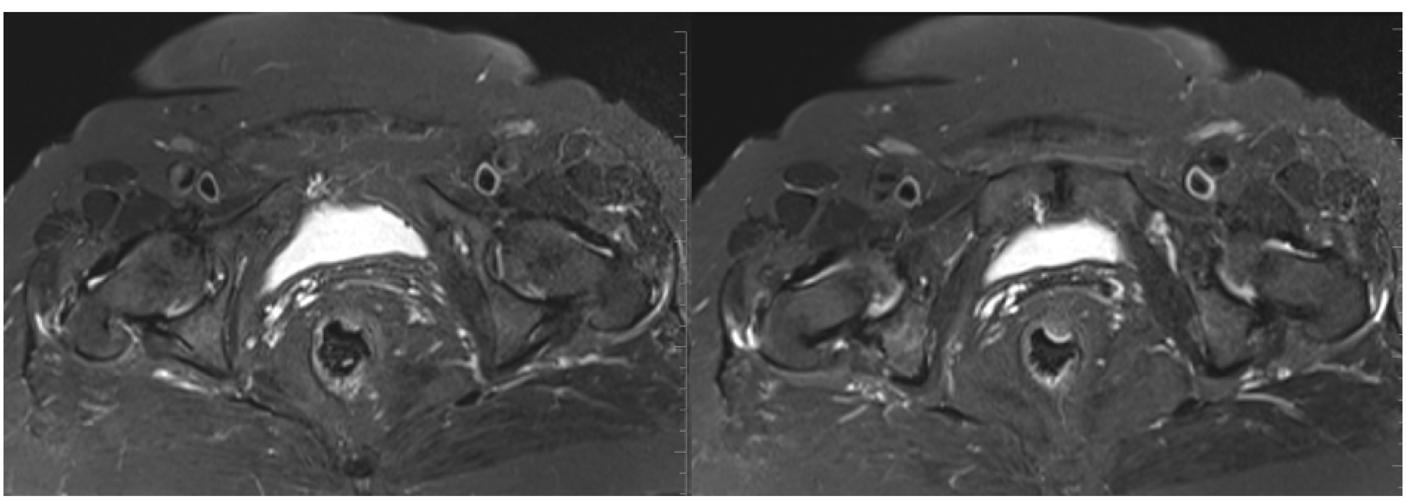

Figure 3. Axial T2-weighted sequences showing localized thickening of the posterior/lateral quadrant of the rectal wall. Signal intensity is pronounced at the submucosal level, with no significant infiltration into the surrounding fatty tissue. No diffuse inflammatory reaction or fistulous tract is observed. The mesorectal fat plane is preserved, and no significant perirectal pathological lymphadenopathy is noted.

The pathogenesis of SRUS is thought to involve rectal prolapse, pelvic floor dysfunction, and mucosal ischemia.[5,6] Habitual digital evacuation may exacerbate mucosal trauma, contributing to lesion development.[7] In our case, rectoanal dyssynergia, chronic constipation, and a history of digital maneuvers were all present.

Treatment options include behavioral modifications, biofeedback therapy, and topical mesalazine.[8,9] Biofeedback has been shown to improve pelvic floor coordination and alleviate symptoms.[9,10] Our patient experienced significant clinical and endoscopic improvement after three months of therapy.

CONCLUSION

SRUS should always be considered in the differential diagnosis of rectal lesions mimicking malignancy. A thorough history, including inquiry about digital evacuation, is essential. Anorectal manometry and defecography should be performed when indicated to evaluate pelvic floor dysfunction. Successful outcomes can be achieved with biofeedback therapy and topical mesalazine.

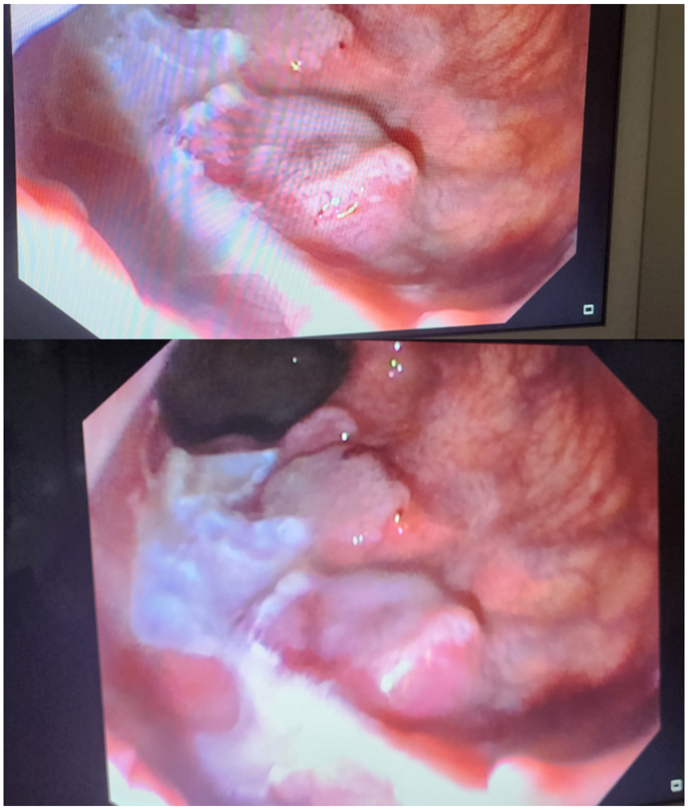

Figure 4. Polypoid lesion on the anterior wall of the rectum, 5 cm from the anal verge, displaying erythematous mucosal patches and superficial ulcerations.

Ethics Committee Approval: This is a single case report, and therefore ethics committee approval was not required in accordance with institutional policies.

Informed Consent: Written informed consent was obtained from the patients participating in this study.

Peer-review: Externally peer-reviewed.

Author Contribution: Concept – R.E; Design – R.E.; Supervision – R.E., M.A.; Resource – R.E.; Materials – R.E., M.A.; Data Collection and/or Processing – R.E.; Analysis and/or Interpretation – R.E., M.A..; Literature Review – R.E., M.A.; Writing – R.E.; Critical Review –R.E., M.A.

Declaration of Interests: The authors declare that they have no competing interest.

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