# **Case Report**

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# Prolapsed rectal polyp in an infant with massive lower gastrointestinal bleeding: case report

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#### **ABSTRACT**

Polyps of the gastrointestinal tract are common cause of rectal bleeding in toddlers and preschoolers. But herein we are reporting prolapsed rectal polyp with massive lower gastrointestinal bleeding in an infant. Rectal polyps in children are juvenile in their majority and are mostly located at the rectum. In a large review series of 563 children aged from 2 months to 17 years the highest incidence of polyps was between ages 2 and 10 years (85.1%). Rectal bleeding was the presenting symptom in 78.5% cases. Though most of them are benign, risk of malignancy is always there if missed.

Keywords: Prolapse, Rectal polyp, Juvenile polyp, Infant, Lower gastrointestinal bleeding

### INTRODUCTION

Polyps of the gastrointestinal tract are common cause of rectal bleeding in toddlers and preschoolers. But herein we are reporting prolapsed rectal polyp with massive lower gastrointestinal bleeding in an infant. Rectal polyps in children are juvenile in their majority and are mostly located at the rectum. In a large review series of 563 children aged from 2 months to 17 years the highest incidence of polyps was between ages 2 and 10 years (85.1%). Rectal bleeding was the presenting symptom in 78.5% cases. Though most of them are benign, risk of malignancy is always there if missed.

# **CASE REPORT**

A one and half year old male infant presented to emergency department with mass in the anal region with profuse bleeding. Infant had similar complaint two months back but the mass reduced spontaneously and bleeding also stopped. Presently infant came with mass in anal region, not reducing, bleeding, and pain. On examination mass seen in the anal region with bleeding (Figure 1).

Vital were stable at the time presentation. All routine blood investigations were done and were posted for emergency surgery. Under GA examination was done and found to be a pedunculated rectal poly arising from the anterior wall of rectum about 5 cm from anal verge (Figure 2).

Surface of the polyp was lobulated with areas if infarction. Pedicle was ligated at the base and polyp was excised. Histopathology showed 3.5x2x1.5 cm polypoidal structure (Figure 3) comprising of abundant cystically dilated glands filled with mucus in an edematous and inflamed stroma, chiefly eosinophils and neutrophils.

These glands are lined by columnar to low cuboidal cell without atypia - juvenile polyp (Figure 4).



Figure 1: Prolapsed rectal polyp (White arrow).

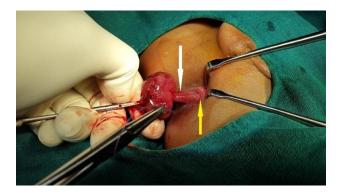


Figure 2: Pedunculated rectal polyp (white arrow) with rectal mucosa (yellow arrow).



Figure 3: Rectal polyp 3 cm in size.

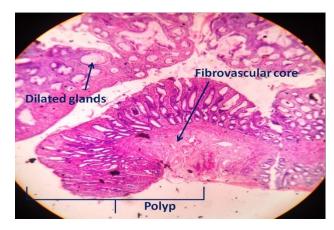


Figure 4: Microscopic appearance of polyp (Juvenile polyp).

#### **DISCUSSION**

Juvenile Polyps (JP) are rare but important causes of acute gastrointestinal symptoms in children. <sup>1</sup> Juvenile polyps may present with hematochezia, prolapse of the polyp from the anus, abdominal pain due to intussusception or may even be asymptomatic. All such polyps should be removed by colonoscopy or transanal resection. <sup>2</sup>

Rectal polyps in children are juvenile in their majority and are mostly located at the rectum. In a large review series of 563 children aged from 2 months to 17 years the highest incidence of polyps was between ages 2 and 10 years (85.1%). Rectal bleeding was the presenting symptom in 78.5% cases. The polyps were solitary in 94% of cases. The majority of polyps (86.3%) were juvenile and 86.7% located in the rectosigmoid area. Three percent of cases had a positive family history. One case of Turcot syndrome was also identified.<sup>3</sup> Polyps must be removed even when asymptomatic because of their probable neoplastic potential.4 Though most JP are located in the left colon, a complete colonoscopy should be the initial procedure because 37% revealed proximal polyps, 32% of polyps were located proximal to splenic flexure, persistence of symptoms from missed proximal polyp(s) necessitates a repeat study with attendant risks, and there is a possibility of malignant transformation in an unidentified JP. A retrospective chart review on 77 children and adolescents with colorectal polyps seen over a 15-year period (1980-1994) recurrence was observed in five of 63 patients (7.9%) with juvenile polyps, in one patient with infantile polyposis, and in one with solitary adenomatous polyp. Authors suggested that a full colonoscopic evaluation should be performed in all patients with suspected polyps if feasible, for multiple polyps occurred in 35% of children without polyposis syndromes in this series. Parents of patients with more than three polyps and/or a family history of juvenile polyposis should be warned regarding the possibility of an increased risk of malignancy in future if polyps continue to recur. Histopathological examination of any removed polyp is important to detect any dysplastic or adenomatous element with malignant potential and to make a suitable follow-up schedule when appropriate.<sup>6</sup>

Here in this patient excision of the polyp was done with adequate hemostasis. Post op child recovered well with no further episodes of bleeding. Infant was followed for two months with no fresh complaints.

## **CONCLUSION**

Rectal polyps are common cause if lower GI bleed in children. Most of them are benign but have malignant potential on long standing and recurrent polyps. Polyps in infants are rare. Hence child with lower GI bleed with polyps should be thoroughly evaluated and treated accordingly.

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