Case Report

Case report - Rectal Diverticuli

Daniela Zammit, John Bonello, Martina Muscat, Kristian Micallef, Pierre Ellul

Case Report

A 56 year old gentleman presented with a long-standing history of constipation and new onset rectal bleeding. The patient underwent a Computed Tomogrophy (CT) Colonography (Figure A) which showed multiple rectal diverticuli and mildly enlarged mesorectal lymph nodes. A flexible sigmoidoscopy was performed and demonstrated the presence of four rectal diverticuli (Figure B).

Daniela Zammit, (M.D.)* Department of Medicine, Division of Gastroenterology, Mater Dei Hospital, Msida, Malta daniela.c.zammit@gov.mt

John Bonello (M.D. MRCP)

Department of Medicine, Division of Gastroenterology, Mater Dei Hospital, Msida, Malta

Martina Muscat, (M.D. MRCP)

Department of Medicine, Division of Gastroenterology, Mater Dei Hospital, Msida, Malta

Kristian Micallef (MRCS, FRCR)

Radiology Department, Mater Dei Hospital, Msida, Malta

Pierre Ellul, (PhD, FRCP)

Department of Medicine, Division of Gastroenterology, Mater Dei Hospital, Msida, Malta

*Corresponding Authors

Rectal diverticuli occur in only about 2% of patients with concomitant colonic diverticular disease. 1-2 The low incidence of this condition has been explained by the uniform disposition of the longitudinal muscle fibres in the rectum (in contrast to the colon) and the lower intraluminal pressure generated in the rectum compared to the colon. They are normally found on the rectal lateral wall due to the support provided by the taenia omentalis and libera, anteriorly, and the taenia mesocolica posteriorly. Rectal diverticula are true diverticuli as they involve all layers of the rectal wall. 3

Most patients are asymptomatic. The finding is usually incidental.⁴ Patients may present with symptoms secondary to faecal impaction or due to complicated disease such as abscess, rectal prolapse, rectal stenosis, recto-vesical fistula and rectal mass.⁵⁻⁶

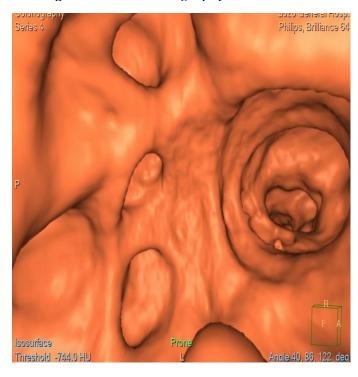
The cause for their formation is yet unknown. Possible risk factors include congenital anomalies such as primary muscle atrophy and absence of the coccyx, 6 longstanding constipation and rectal trauma. 4 latrogenic causes can occur secondary to stapled haemorrhoidoplexy or stapled transanal haemorrhoid resection. 7 Surgery is reserved for complicated disease. 8

Keywords

Rectum; Diverticuli; Colonography; Endoscopy.

Case Report

Figure A: CT Colonography – Rectal diverticuli



 $\textbf{\textit{Figure B:}} \ \textit{Flexible Sigmoidoscopy} - \textit{Rectal diverticuli}$



Case Report

References

- 1. Walstad PM, Sahibzada AR. Diverticula of the rectum. *Am J Surg* 1968; **116**(6):937-9.
- 2. Spriggs EI, Marxer OA. Multiple diverticula of the colon. Lancet 1927; 212:1067-74.
- 3. Piercy KT, Timaran C, Akin H. Rectal diverticula: report of a case and review of the literature. Dis Colon Rectum 2002. 45:1116-7.
- 4. Chen CW, J SW, Lai HJ, Chiu YC, Kang JC. Isolated rectal diverticulum complicating with rectal prolapse and outlet obstruction: Case report. World J Gastroenterol 2005. 11(48):7697-99.
- 5. Damin DC, Rosito MA, Tarta C, Contu PC. Giant rectal diverticulum presenting as an ischiorectal abscess. Tech Coloproctol 2005. 9:249-50.
- 6. Jung SH, Kim JH. A Case of Solitary Rectal Diverticulum Presenting with a Retrorectal Mass. Gut Liver 2010. 4(3):394-7.
- 7. Pescatori M, Spyrou M, Cobellis L, Bottini C, Tessera G. The rectal pocket syndrome after stapled mucosectomy. Colorectal Dis 2006. 8(9):808-11.
- 8. Fagundes RB, Motta GL, Fontana K, Fonseca CB, Binato M. Rectal Diverticulum. ABCD Arq Bras Cir Dig. Letter to the Editor. 2011. 24(4):339-41.