

# Rectal bleeding in children

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**Abstract**— Rectal bleeding is quite common in children. Often the bleeding is self-limiting. Rectal polyps are very important cause of rectal bleeding. Infections like shigellosis are important causes and should be kept in mind for differential diagnosis.

**Keywords**— Bleeding, Rectum, Stool, Dysentery, Rectal polyp.

## I. INTRODUCTION

Rectal bleeding in children is quite common and parents become very anxious due to the sight of blood in stool. So the presentation to doctors is relatively early than in other disease conditions. The positive part is the bleeding is often self limiting and mostly benign in nature. Bleeding can be painful or painless, mild to severe & intermittent or continuous. The incidence is about 0.3%. Bleeding may be streaks on the stool, drops or admixed with loose stool & rarely profuse.

## II. AETIOLOGY

The commonest cause of rectal bleeding is local in the anal canal<sup>1,2</sup> or rectum. Occasionally it may come from higher locations like colon and small gut. It can originate very rarely from stomach or duodenum particularly in brisk bleeding. Of the local causes anal fissure accounts for the majority of cases. The second most common cause is polyps. Most of the polyps are hamartomatous or hyperplastic. Other polyploidal conditions e.g. PJ syndrome or FAP may be the source of bleeding. Intussusceptions are an important cause to be remembered particularly during weaning period. Another important cause of bleeding is prolapse rectum. Rarer causes include HD, stercoral ulcer, haemorrhoids, Meckel's diverticulitis, IBD, Diverticulitis, mesenteric ischemia, volvulus etc. Medical conditions which are associated with bleeding per rectum are dysentery, allergic enteritis, infectious diarrhoea (campylobacter & clostridium difficile), Henock Shonlein purpura etc.

Children are brought to hospital or doctor's chamber by parents mostly on first bleed or quite early unlike in adults who ignore it for a long time. Unless severe in nature children do not have any complaints. Cramping pain may be experienced by some during the episode & vomiting is very rare. History of constipation and passing hard stool is

commonly obtained specially in fissure and HD. Pallor is present in chronic blood loss or severe haemorrhage. Pigmentation and patchial spots may be detected in PJ syndrome or Henoch Shonlein purpura. A palpable sausage shaped mass in the central abdomen is diagnostic of intussusceptions. Abdominal distension and visible peristalsis may be found in volvulus or HD. Perianal skin tags, fissures & prolapsed rectum are diagnostic on perianal examination. Digital rectal examination will confirm the presence of fissure, polyp or ulcer. Proctoscopy & sigmoidoscopy will reveal most of the pathologies in the anal canal, rectum & sigmoid colon<sup>3</sup>.

## III. INVESTIGATION

In most of the cases diagnosis is confirmed by clinical examination alone with the help of proctoscopy and sigmoidoscopy and treatment advised. Investigations include CBC, PT, APTT, ESR, C-reactive protein to exclude haemorrhagic disorder and IBD. Stool microscopy and culture is indicated in cases of bleeding with diarrhoea. Colonoscopy<sup>4</sup> & Gastroduodenoscopy are carried out to visualise and document the pathology in proximal bowel. Technetium scan is the investigation of choice to diagnose Meckel's. Polyps should be sent for biopsy to ascertain the nature.

## IV. TREATMENT

Treatment should start as early as possible. Medical causes need immediate attention with proper diet, fluid & drugs. In anaemic patients haematinics & blood transfusion may be necessary. Anal Fissure needs conservative management which include bowel training, fluids & laxatives. Rectal polyps are removed digitally or by snares & they need histopathological examination<sup>6</sup>. Multiple polyposes should be investigated thoroughly regarding their nature and appropriate treatment suggested. Prolapse of rectum is reduced manually, diarrhoea controlled and weight gain encouraged. Operative reposition is occasionally indicated. Bleeding from Meckel's diverticulum dictates surgical excision on an emergency basis. Stress ulcers are becoming common nowadays in ICU children if proper care is not taken. IBD and other colitis are not rare & early diagnosis & treatment in a paediatric setting is recommended.

## V. CONCLUSION

In cases of diarrhoea with bleeding conservative management is indicated. Stool microscopy and culture are of paramount importance in such cases. In severe cases hospitalisation is mandatory. Blood dyscrasias causing rectal bleeding needs admitting in Paediatric unit for evaluation & proper treatment. As most of the cases are of benign nature and self limiting explanation, assurance and "safety netting" is indicated.

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