

Letters to the Editor

Rectal ulcer induced by suppositories

Key words: Rectal ulcer. Suppositories abuse. Analgesic suppositories. Opiate addiction. Rectal bleeding.

Dear Editor,

It is difficult to diagnose rectal ulcer secondary to excessive analgesic suppositories administration as many patients deny their use. This pathology is most commonly observed in middle-aged women suffering from neurosis. Extensive differential diagnosis is needed to rule out colon carcinoma, inflammatory bowel disease and other severe disorders.

Case report

We report the case of a 40-year-old woman who was referred to our hospital for rectal bleeding with clots of 24 hours' duration. She also complained of anorectal pain at defecation, urgency and constipation over the previous year. Rectal bleeding stopped spontaneously one day after admission.

She was self-medicated for headaches with paracetamol-codeine suppositories (500/30 mg).

Physical examination was normal but digital rectal examination was painful, showing induration and irregularities of the mucosa, and fresh blood.

Analytics and chest and abdominal-X-ray were normal. Total colonoscopic examination revealed loss of normal mucosal vascularization pattern and diffuse ulceration of the rectal mucosa with some isolated pseudopolyps, extending proximally 10 cm

from the anus. Microscopic examination of the biopsies showed non-specific ulceration. CT examination observed concentric rectal narrowing, and perirectal adenopathies. Serologies and tuberculin test were negative.

On further questioning, the patient admitted to the administration of up to 16 suppositories of paracetamol and codeine per day over the last year. Rectitis-rectal ulceration secondary to paracetamol-codeine suppositories was diagnosed together with opiate-addiction syndrome following psychiatric evaluation.

Treatment with suppositories was stopped and enemas of hydrocortisone were prescribed, together with benzodiazepines for the opiate addiction syndrome. The patient improved significantly and was discharged.

Colonoscopies performed at 2 (Figs. 1 and 2) and 6 months after discharge showed progressive improvement and healing of the rectal lesions. Treatment was stopped 8 months after diagnosis.

Discussion

Rectal ulcer associated to analgesic suppository abuse is a poorly known entity and few reports can be found in the literature. It most commonly affects middle-aged women and is generally associated with a background of neurosis. Most patients present a history of chronic headache with chronic auto-administration of suppositories. The most frequently involved suppositories are those containing non-steroid anti-inflammatory drugs (NSAIDs) and paracetamol-codeine (1).

Women do not usually spontaneously recognise suppository abuse (3). When such administration is suspected drug metabolites can be determined in urine. Previous history of trauma, rectum-anal surgery or local radiotherapy should be ruled out (3).

Physiopathology is poorly known. Codeine is responsible for the addiction (1), and it is as yet unknown how paracetamol damages rectal mucosa (2). In addition, local trauma due to suppository introduction could contribute to the development of stenosis (4).

Symptoms are false urge to defecate, rectal tenesmus, anal pain, rectal bleeding, mucus discharge and constipation (2), with

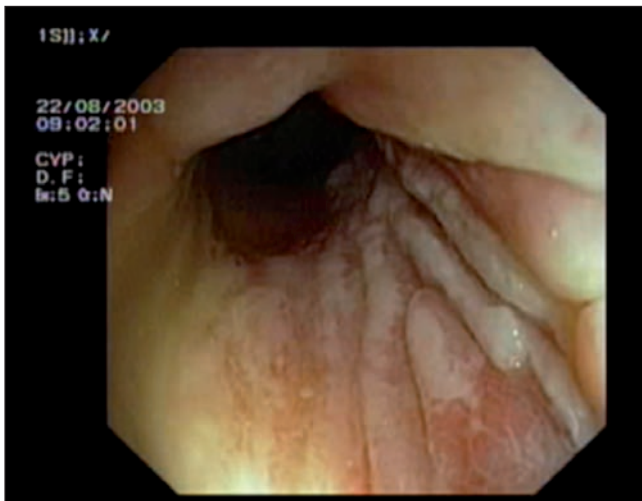


Fig. 1. Erythematous mucosa, with loss of normal vascularization pattern and irregular, enlarged folds. Mild stenosis of the rectum.

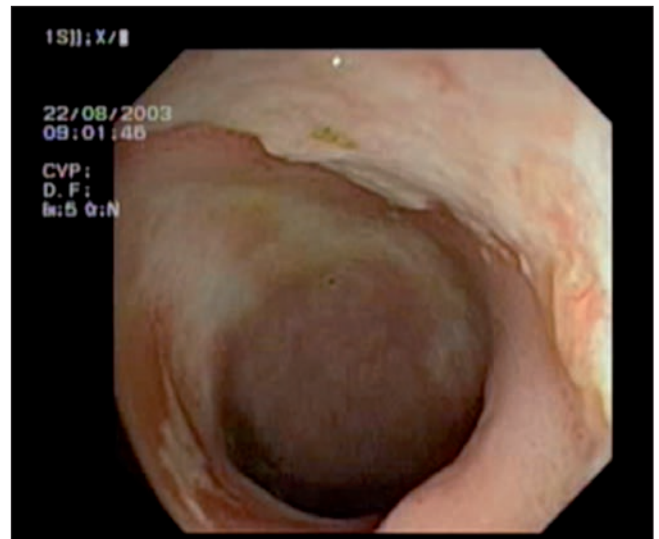


Fig. 2. A wide area of fibrin in upper right, and another ulceration with fibrin in lower left, surrounded by erythematous mucosa.

intestinal obstruction secondary to stenosis in severe cases (3). In 50% of cases there are perianal skin lesions (1).

Colonoscopy findings are often diffuse mucosal inflammation, with ulcerations and pseudopolypoid lesions. Severe cases can develop rectal fibrotic stenosis or intramural fistula (3). CT shows thickening of the rectal wall, with inflammatory changes in perirectal fat and non-specific adenopathies (3). The histology shows non-specific inflammation (1).

The differential diagnosis should include inflammatory bowel disease, granulomatous disease, anorectal carcinoma, solitary rectal ulcer, ischemic disease and iatrogenic lesions (1-3).

Treatment in all cases is discontinuation of suppositories and topic steroids. Endoscopic dilatation can be useful in cases with rectal stenosis, and surgery may be necessary in severe stenosis (2,3). Evolution is generally favourable within weeks, and patients remain asymptomatic.

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