Short reports

Colorectal polyps: an important cause of rectal bleeding

V N PERISIC

Institute for Child and Mother Care, Novi Beograd, Yugoslavia

SUMMARY Seventy one children with rectal bleeding were examined by total fiberoptic colonoscopy. Large bowel polyps were found in 45; 27 (60%) had solitary rectal polyps. Altogether, 83% of resected polyps were juvenile. No complication of colonoscopic polypectomy occurred. New polyps reoccurred in four (9%) treated children.

Rectal bleeding is an alarming symptom in children but often not life threatening. Colorectal juvenile polyps may be a common cause of rectal bleeding in the preadolescent age group. Although polyps may often undergo auto-amputation, profuse bleeding or malignancy may sometimes occur.¹⁻³ Colocolic invagination, rectal prolapse, massive rectal bleeding, or recurrent abdominal pain may complicate non-resected polyps. A recent case of large bowel carcinoma complicating juvenile polyps showed the need for a more stringent diagnostic and therapeutic approach.

From 1981 to 1986, 71 children with rectal bleeding were studied by means of total fiberoptic colonoscopy. Large bowel polyps were diagnosed in 45 children (63%); all were resected during colonoscopy. Details of investigation, treatment, and follow up of children with colorectal polyps are presented.

Patients and methods

Seventy one children with recent lower gastrointestinal bleeding were investigated by total colonoscopy. Their mean age was 7.3 years (range 8 months to 16 years). The patients were admitted to hospital on the day before examination. The methodology of Williams *et al* was used for bowel preparation, sedation, instrumentation, and the technique of total colonoscopy.³ Blood was cross matched and available before polypectomy. An adult Olympus colonofibroscope CF-LB3, Olympus electrosurgical unit PSD-2, and MTW polypectomy snares (Wesel, West Germany) were used. The duration of the colonoscopy was not more than 30 minutes. After

polypectomy the children were observed for 24 hours and then discharged.

Results

The diagnoses of the 71 patients are summarised in Table 1. Large bowel polyps were found and resected in 45 children (63%); 27 (60%) had solitary rectal polyps. They were mostly 10-12 mm in diameter and easy to snare and resect. Table 2 summarises the distribution of the polyps. Of the resected polyps, 83% were juvenile and 8% inflammatory. In addition, one adenomatous, one Peutz-Jeghers, and two right colonic lymphoid

Table 1 *Colonoscopic diagnosis of rectal bleeding in 71 patients*

Diagnosis	No (%)
Polyps	45 (63)
Ulcerative colitis	13 (18)
Follicular and nodular lymphoid hyperplasia	2 (3)
Hemangioma	2 (3)
Unknown cause	9 (13)

Table 2 *Distribution and numbers of polyps in 45 patients with large bowel polyps*

Site of removal	No of polyps	No of patients
Rectum	1	27
Rectum	2	2
Rectum and sigmoid colon	2	2
Rectum and descending colon	2	1
Rectum, sigmoid and transverse colon	3	1
Sigmoid colon	1	5
Sigmoid colon	2	1
Ascending colon	1	1
Caecum	1	1
Polyposis:		
Juvenile	15	1
	90	1
	Many	1
Inflammatory	Many	1
Total		45

*Many=Too many to count.

polyps were resected. One child with a bleeding juvenile polyp was also found to have ileal nodular lymphoid hyperplasia, and two children with ulcerative colitis in remission bled from juvenile polyps in the rectum and sigmoid colon.

No complications arising from polypectomy were encountered. New polyps (three in the rectum and one in the sigmoid colon) occurred in three children after a minimum of eight months).

Discussion

This study shows that colorectal polyps may be responsible for a surprisingly large proportion of cases of rectal bleeding in childhood, particularly where the incidence of inflammatory bowel disease is not high.¹⁻⁶ It also confirms the value of total colonoscopy in investigating children with lower bowel bleeding; digital examination, single contrast barium enema, and proctoscopy alone are insufficient. We have abandoned the use of large bowel radiology in our hospital because of the superiority of colonoscopy in detecting polyps. We were unable, however, to compare the diagnostic values of these methods in children.

Bleeding from the lower gastrointestinal tract may have two simultaneous causes in one child: ileal nodular or follicular lymphoid hyperplasia. Colorectal polyps were seen in two patients with quiescent ulcerative colitis. Failure to detect the

polyps could have led to a wrong diagnosis that the inflammatory bowel disease was in relapse.

Histology of resected polyps showed that juvenile polyps predominated, as has been found in previous studies.¹⁻⁶ The finding of a large bowel adenoma in a 2 year old boy is particularly important as such lesions can be premalignant. Thus the removal of all large bowel polyps in children as well as in adults is essential, even in the case of histologically confirmed juvenile polyps.

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Correspondence to Dr V N Perisic, Institute for Child and Mother Care, Radoja Dakica 6-8, 11070 Novi Beograd, Yugoslavia.

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Hearing loss due to mumps

R HALL AND H RICHARDS

Clwyd Health Authority, Mold and Wrexham, Clwyd, Wales

SUMMARY The possibility of mumps was considered in 33 children with profound unilateral sensorineural hearing loss of unknown origin. Fifteen gave a history of mumps, of whom 12 contracted the infection between the last normal and first abnormal hearing tests. Hearing should be tested after mumps infection.

The epidemiology of mumps in England and Wales is reported to be changing from an epidemic disease of young adults and older children to a more endemic disease affecting younger age groups, with an associated change in the age distribution of general practitioner consultations.¹ Although the

incidence of recognised clinical disease may be falling, mild and symptomless mumps infections are possibly more common. Complications of mumps may arise, irrespective of the severity of infection, and can occur in the absence of parotitis.²

Deafness is a widely recognised complication of mumps, characteristically unilateral and sensorineural in nature, and is thought to result from endolymphatic labyrinthitis.² The hearing loss is usually acquired suddenly, four to five days after the onset of illness, and results in permanent profound hearing impairment. The incidence of this complication has been regarded as rare, of the order of 0.05/1000 cases,³ although unrecognised mumps can cause severe deafness.⁴

This study reports an investigation undertaken in