Case Report
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Homoeopathic Management of Second-Degree Rectal Prolapse in a Child: A Case Report

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ABSTRACT

Rectal prolapse in pediatric patients represents a distressing and recurrent clinical condition characterized by the protrusion of rectal mucosa due to weakness of the pelvic support structures. Conventional management often includes dietary correction, stool regulation, pelvic floor strengthening, and surgical intervention in persistent cases.

This case report documents the management of second-degree rectal prolapse in a 9-year-old child using individualized homoeopathic treatment along with supportive care. A carefully selected constitutional remedy with a supportive tissue remedy was associated with progressive clinical improvement over three months without invasive procedures.

The case highlights the potential role of homoeopathy as a conservative and child-friendly therapeutic approach in pediatric rectal prolapse while acknowledging the need for further systematic clinical studies.

Keywords: Rectal prolapse, pediatric homoeopathy, Ruta graveolens, Calcarea phosphorica, conservative management

INTRODUCTION

Rectal prolapse is a condition in which part or all of the rectal wall protrudes through the anal opening [1,4]. It is most commonly observed in children between 1 and 4 years of age and is generally benign and self-limiting in this age group [1,2].

However, persistent cases may cause considerable concern for caregivers due to the visible protrusion of mucosal tissue during or after defecation. The condition is frequently associated with chronic constipation, malnutrition, parasitic infestation, and increased intra-abdominal pressure [1,3].

Homoeopathic medicine aims to treat patients based on individualized symptom totality and constitutional characteristics. This report presents a case of pediatric rectal prolapse managed with individualized homoeopathic treatment and supportive care.

CLINICAL CONTEXT AND SUPPORTIVE MANAGEMENT

The child had a history of chronic constipation and straining during defecation. Dietary advice was provided to the guardian, including increased intake of fiber-rich foods, adequate hydration, and the establishment of regular bowel habits while avoiding prolonged straining during defecation.

No conventional stool softeners or laxatives were administered during the treatment period. According to parental history, deworming medication had been given approximately six months earlier during a routine pediatric consultation.

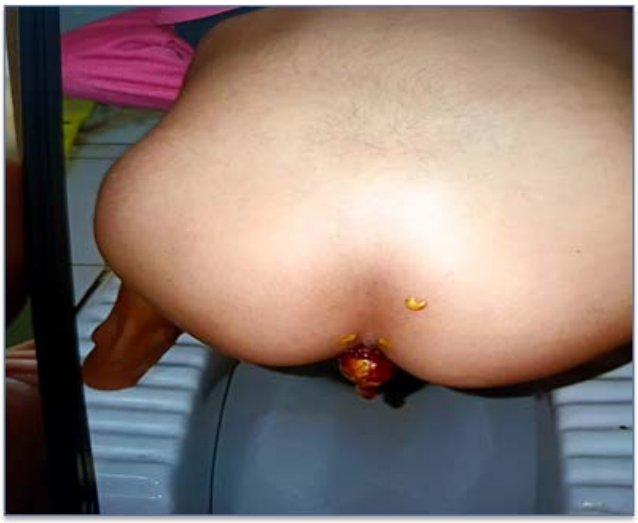
The child had previously been examined by a pediatric practitioner who confirmed that the prolapse was reducible and advised conservative management. Surgical intervention was not considered necessary at that stage.

DIAGNOSTIC EVALUATION

The diagnosis of second-degree rectal prolapse was based on clinical examination and patient history. The prolapse appeared during straining and initially required manual reduction.

Basic evaluation included a general physical examination, nutritional assessment, hemoglobin estimation, and stool examination for parasites. Stool examination did not reveal active parasitic infestation. Hemoglobin levels suggested mild anemia, consistent with the pale mucosa noted on examination.

There were no clinical features suggesting cystic fibrosis, such as recurrent respiratory infections or severe failure to thrive; therefore, advanced investigations were not considered necessary.



CASE DOCUMENTATION

Age: 9 years

Sex: Male

Anthropometric Data

Weight: 22 kg

Height: 126 cm

Nutritional status: mildly underweight for age

Birth History

Full-term normal vaginal delivery with no neonatal complications.

Developmental History

Developmental milestones were achieved at appropriate ages.

Past Medical History

History of chronic constipation for approximately one year.

Family History

No family history of rectal prolapse or hereditary gastrointestinal disorders.

Associated Symptoms

Fear of defecation due to pain, irritability, and generalized weakness. There was no history of chronic cough, neurological disorders, or previous anorectal surgery.

TOTALITY OF SYMPTOMS

- Rectal prolapse during stool
- Constipation with straining
- Fear of pain during defecation
- Emaciation
- Irritability
- Desire for sweets

REPERTORY SYNTHESIS

- Rubrics considered:
- Rectum – prolapse – during stool
- Rectum – weakness – sphincter
- Constipation – straining
- Fear – anticipation of pain
- Children – weakness
- Desire – sweets

Leading remedies obtained in repertorization included Ruta graveolens, Podophyllum, Aloe, Silicea, and Calcarea phosphorica.

REMEDY SELECTION AND PRESCRIPTION

Ruta graveolens 200C – single dose

Calcarea phosphorica 6X – twice daily

Ruta graveolens was selected due to its clinical affinity for weakness of connective tissues and prolapse conditions. Calcarea phosphorica was prescribed as a supportive tissue remedy considering the child's constitutional features, including emaciation, irritability, and general weakness.

FOLLOW-UP AND OUTCOME

Clinical progress was assessed during monthly follow-up visits over a period of three months.

The frequency of prolapse episodes reduced from daily occurrences at baseline to occasional episodes in the first month, followed by minimal self-limiting protrusion in the second month. By the third month, no further prolapse episodes were reported.

Pain during defecation, bleeding, and straining gradually decreased, and stool consistency improved from Bristol Type 1–2 to Type 4.

Outcome measures were based on clinical observation and parental reporting during follow-up consultations. Although no recurrence was reported during the three-month observation period, longer follow-up would be required to confirm sustained remission.

DISCUSSION

Rectal prolapse in children is frequently associated with chronic constipation, malnutrition, and conditions that increase intra-abdominal pressure [1,4]. Conservative management, including dietary correction and bowel regulation, often leads to improvement.

The present case demonstrated progressive improvement following individualized homoeopathic treatment combined with supportive measures. However, spontaneous resolution is known to occur in pediatric rectal prolapse; therefore, the observed improvement should be interpreted cautiously [1,2].

Homoeopathic remedy selection in this case was based on the totality of symptoms and repertorial analysis [5-8]. Further systematic studies and larger clinical investigations are required to evaluate the role of homoeopathy in such conditions.

LIMITATIONS

This report represents a single clinical case with a short follow-up period of three months. Objective investigations were limited, and outcome assessment relied partly on parental reporting. Therefore, the findings should be interpreted as a clinical observation rather than definitive evidence.

CONCLUSION

Individualized homoeopathic treatment combined with supportive care was associated with clinical improvement in this pediatric case of rectal prolapse. Further controlled studies are required to evaluate the broader therapeutic role of homoeopathy in such conditions.

ETHICAL CONSIDERATIONS

Written informed consent was obtained from the child's guardian for academic publication of this case report. Institutional ethical approval was not required for a single anonymized case report according to applicable guidelines.

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