INTRODUCTION

Solitary rectal ulcer syndrome is an uncommon and often underdiagnosed condition that usually presents with hematochezia, mucous discharge, and tenesmus. Its etiology is unknown but it seems related to excessive straining with defecation. Prolonged efforts force the anterior rectal mucosa into the anal canal with strangulation and appearance of congestion, edema, and ulceration ***(Martín et al., 2007).***

Diagnosis can usually be made on sigmoidoscopy, and biopsies should always be taken. Histological features are well established as obliteration of the lamina propria by fibrosis and smooth-muscle fibers extending from a thickened muscularis mucosa to the lumen ***(Crespo Pérez et al., 2007).***

Radiological appearances have been described on transrectal and endoanal ultrasound, defecating proctography and barium enema ***(Amaechi et al., 2010).***

Treatment modalities include dietary management, biofeedback, salicylate enema, steroid enema, and local injection of corticosteroid. Severe symptoms (e.g. massive bleeding, spasm, and severe pain) may require temporary colostomy. Surgical therapy to correct rectal prolapse is indicated in highly symptomatic patients who do not respond to conservative management ***(Yagnik, 2011).***