
Idiopathic sigmoid megacolon - a case report**Dr. Nitin Kalaskar¹, Dr. Vinayak Ingalalli²**¹Associate professor, Dept of surgery, M R Medical College, Kalaburagi, Karnataka²Post graduate, Dept of surgery, M R Medical College, Kalaburagi, Karnataka***Corresponding author**

Dr. Vinayak Ingalalli

Email: ingalalli@gmail.com

Abstract: Faecal impaction is a disorder characterized by a large mass of compacted faeces in the rectum and/or colon, which cannot be evacuated. Such impaction causing emergencies is rare and seldom reported. Here, we report a case of 45 years old male presenting to the emergency department with massive abdominal distension, abdominal pain and obstipation. Abdominal CT scan was done which revealed the gross dilatation of whole of the large bowel especially the sigmoid colon was distended massively measuring 18x14cm over 34cm filled with faecal material. Attempts to relieve an obstruction were failed to relieve obstruction and, was taken for emergency laparotomy. Debulking of whole of the colon was done with enterotomy of 0.5cm to evacuate the gas and bowel was totally decompressed of faecal material per rectally and excision of involved sigmoid colon with colo-rectal anastomoses was done. Post operative period was uneventful. Patient was advised with healthy bowel habits and stool softeners and was discharged after 15 days of surgery.**Keywords:** Faecal impaction, Megacolon, Large bowel obstruction.**INTRODUCTION**

Megacolon is an abnormal dilatation of the colon caused by non-mechanical obstruction. The dilatation is often accompanied by a paralysis of the peristaltic movements of the bowel resulting in chronic constipation. A megacolon can be either acute or chronic. Most of them are managed conservatively. Rarely merits the surgical intervention.

CASE REPORT

A case of 45 years male presented with massive abdominal distension – 10days, pain abdomen and obstipation – 2days, also gave history of constipation and similar complaints in the past for which he was treated non operatively. On examination the abdomen was grossly distended, tense and tender, resonant note on percussion and no bowel sounds were heard. On per rectal examination no mass felt and rectum was empty. Abdominal girth at the level of umbilicus was 84cms. Vitals stable. Nasogastric tube and foley catheter were put and flatus tube was put per rectally but failed. Erect abdomen xray was done and it showed distended bowel loops and CT scan showed grossly distended large bowel especially sigmoid colon with impacted stool in the rectum compressing the small bowel loops.

Because of the failed conservative management patient was taken up for emergency laparotomy. On exploration, the large bowel was distended especially the sigmoid colon. The gas and the

liquid stool were evacuated through the small enterotomy and total decompression of the bowel was done through per rectal evacuation of impacted stools. Distended sigmoid colon was excised and colorectal anastomoses was done. The post operative period was uneventful and he was discharged after 15days of surgery with advice on high fiber diet and stool softeners.



Fig-1: Xray erect abdomen shows distended bowel loops

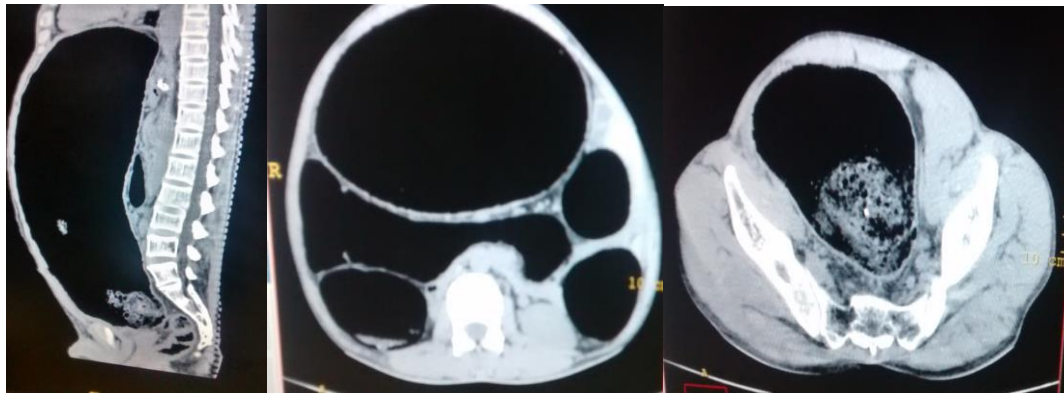


Fig-2: CT Abdomen (P) sagittal and axial view shows grossly distended large bowel especially sigmoid colon with impacted stool in the rectum compressing the small bowel loops.

DISCUSSION

The exact etiology of idiopathic megacolon is not known. By definition, megacolon implies persistent increase in the diameter of the colon always associated with longstanding constipation. This clinical condition is often found in the elderly, chronically constipated. The leading clinical symptom is considerable abdominal suffering from intractable chronic constipation that responds poorly to pharmacological treatment and nonsurgical interventions [1, 2].

A number of different conditions cause large bowel dilatation in association with severe constipation, including Hirschsprung's disease, chronic idiopathic intestinal pseudoobstruction, and idiopathic megarectum or megacolon. The condition frequently starts in childhood or adolescence, and fecal impaction is common. In contrast to idiopathic megarectum, patients with idiopathic megacolon usually do not experience impaction, and the symptoms often initiate in adult life [2].

Clinical signs and symptoms of the idiopathic megacolon onset in adult life are constipation (major symptom), alternating diarrhea and constipation, abdominal pain, abdominal swelling, fecal soiling and palpable abdominal mass [3].

The diagnosis of the megacolon is made on the characteristic clinical and radiological findings [4, 5]. Imaging modalities have a major role in diagnosis and follow-up of the patients with idiopathic megacolon. Complications that occur during follow-up can also be shown by imaging modalities. Because of the gas content of the dilated colonic segment, the role of the US is limited. At CT scan, dilated colonic segment, the wall and the lumen of this segment, obstructive causes, secondary findings due to complications such as perforation can readily be shown with a high efficacy. Colonic marker transit studies are useful to differentiate colonic inactivity from functional outlet obstruction etiologies. A colonoscopy can also be used to exclude mechanical obstructive causes. Anorectal manometry may help to differentiate acquired from congenital

forms. Rectal biopsy can be necessary to make a final diagnosis [4, 5].

Most of the cases can be managed conservatively [6] Surgery is clearly indicated if there is evidence of volvulus, and colectomy with ileorectal anastomosis should be considered in those with disabling symptoms. Volvulus may not be an uncommon complication of this condition [7]

CONCLUSION

The clinical case described here gives rise to serious reflection on the difficulty in planning the diagnostic strategy of a chronic and progressive disease. Even though the identifiable cause is absent, the surgeon should go for the resection of the involved segment of the bowel to prevent the recurrence.

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