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Letters to the Editor

Chagas disease in the differential diagnosis of megacolon

Key words: Chagas disease. Fecaloma. Megacolon. Surgical treatment.

Dear Editor,

Chagas disease (CHD) is endemic in the Americas but due to increased immigration is becoming increasingly common in our country. It is caused by *Trypanosoma cruzi* (1) that is transmitted by blood-sucking insects, blood transfusions or fetal transmission (1,2). The CHD has three phases: an acute (non-specific symptoms) (3), one asymptomatic (antibody positive) and a significant chronic cardiac disease (leading cause of death) (4) and formation of digestive megavisceras such as megaesophagus and megacolon (5). The diagnosis depends on the stage of the disease and treatment is applicable only in the acute phase.

Case report

We report a case of a patient 41 years old, from Argentina, who went to the emergency room with abdominal pain and constipation. On examination, she presented lower abdominal discomfort with feeling lower abdominal mass. Gynecological pathology was ruled out and was done Rx abdomen showing abundant fecal material. The blood test with tumor markers was normal and an abdominal CT objectived fecal and recto-sigmoid colon dilation (Fig. 1). Cleansing enemas are effective and fibrocolonoscopy was normal. During admission the patient was interrogated again and in her family history stands out the death of his mother for cardiac disease at the age of 45. CHD serology was performed being positive. The patient underwent conservative treatment with good evolution and was discharged without surgical intervention.

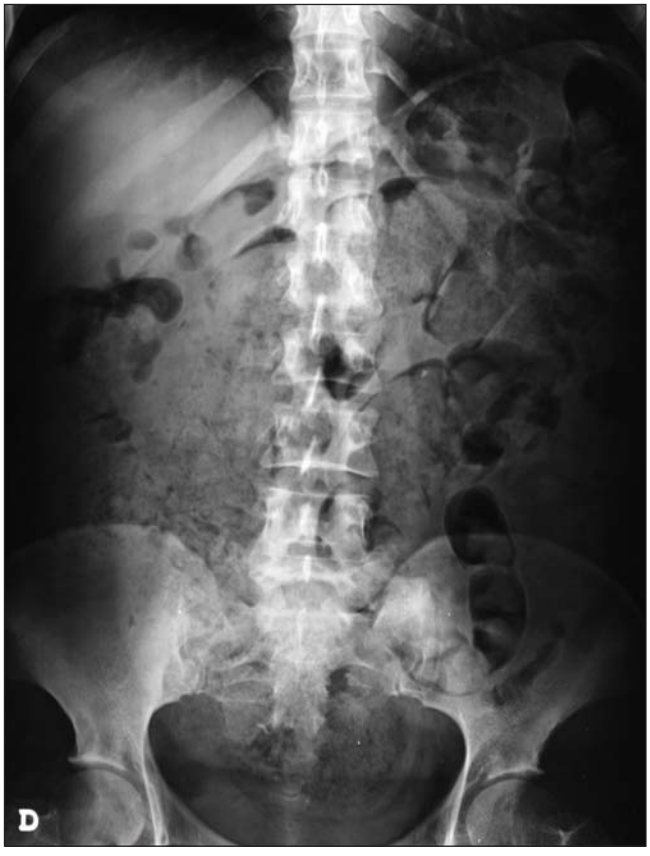

Fig. 1. Abdomen CT that shows a fecalota with colonic dilatation.

Discussion

Megacolon is an abnormal dilation of the colon that can be caused by several factors: primary, by alterations of ganglion cells of Auerbach and Meissner plexus, congenital (Hirschsprung disease) or secondary to diverse neurological, metabolic, infectious, connective tissue connective psychogenic and medicines (4). The pathophysiology of CHD is not entirely known. Treatment of megacolon secondary to CHD should be to prevent surgical complications. Conservative treatment is reserved for patients oligosymptomatic or with surgical contraindications (5). Most patients with CHD have some type of heart disease, so they tend to be high risk for surgery (6). Because of the morbidity involving the preservation of the affected colon segment, is reflected in the literature a tendency to prefer resection techniques for the derivative. Currently the two most accepted are the Duhamel-Haddad technique (6,7), which takes place two times and has the disadvantage of carrying a temporary perineal colostomy. The other is the Habr-Gama technique that causes the posterior colorectal anastomosis, immediately, with acceptable results (8). Subsequently, new variations have been postulated as the rectosigmoidectomy with ileal interposition, with good results and decreased recurrence (9,10). Although CHD is a tropical disease we have to think about it, in front of patients, especially from South America, who come to our clinic presenting symptoms secondary to the presence of digestive megavísceras.

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