

PICTURES IN DIGESTIVE PATHOLOGY

Idiopathic megarectum and megacolon

J. Molina Infante, M. Hernández Alonso, B. Pérez Gallardo and E. Martín Noguerol

Unit of Gastroenterology. Hospital San Pedro de Alcántara. Cáceres, Spain

CASE REPORT

A 56-year-old female with a prior medical history of congenital mental retardation, hypercholesterolemia, and hypothyroidism consulted for severe constipation refractory to laxatives, which required enemas for evacuation, associated with abdominal distension and weight loss –8 kg over the last six months–. Physical examination revealed a hard, long, rounded mass measuring 8 x 10 cm in the central hypogastrium. Laboratory parameters, including acute phase reactants and tumor markers, were within normal ranges, and a gynecological echogram was normal. An abdominal computerized tomography scan (Fig. 1, coronal reconstruction; Fig. 2, axial images) showed a giant dilation of the rectum and left bowel, occupied by multiple compacted feces, displacing the abdominal viscera and resulting in bilateral hydronephrosis without renal failure. A colonoscopy reaching the cecum, biopsies, and pelvic magnetic resonance imaging were all normal, while rectoanal manometry disclosed a proper relaxation of the internal anal sphincter in response to rectal distension. Treatment with oral polyethylene glycol electrolyte solution and rectal lactulose led to progressive clinical improvement, and the patient had a successful outcome on maintenance therapy with oral lactulose.



Fig. 1.

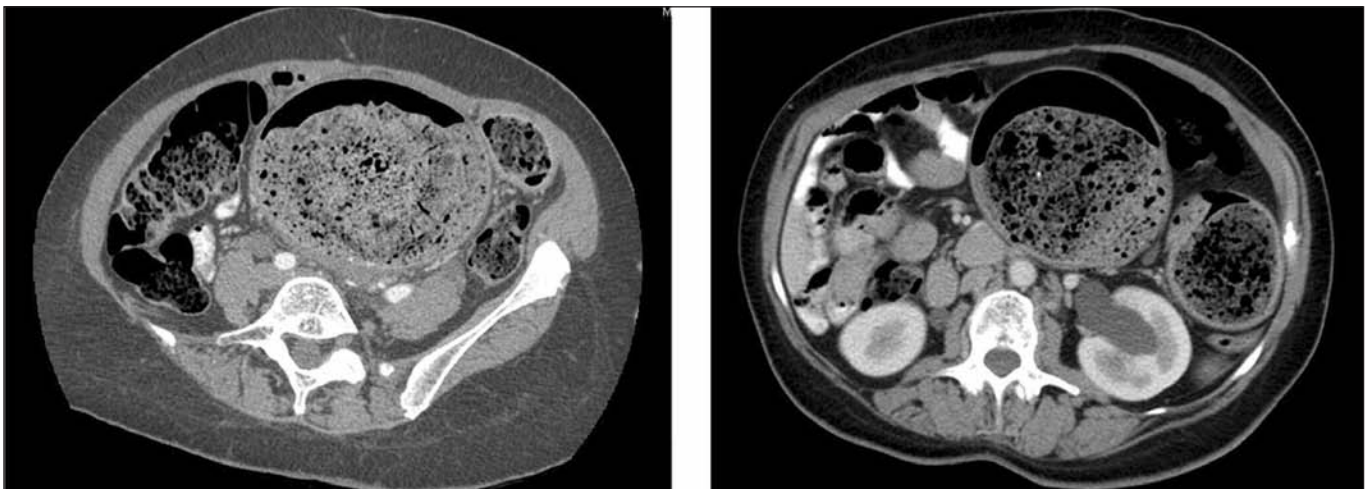


Fig. 2.

DISCUSSION

Chronic constipation with megacolon or megarectum is an uncommon and poorly characterized condition that requires diagnosis of exclusion. Primary megacolon is thought to be associated with neurogenic dysfunction and secondary megacolon and megarectum often develop later in life and may occur in response to chronic fecal retention in patients with intellectual impairment or psychiatric disease. In this setting, constipation may be associated with fecal impaction and soiling. Anorectal physiological testing usually discloses decreased rectal sensations, and a rectoanal inhibitory reflex can be demonstrated in most patients, which distinguishes this disorder from Hirschprung's disease. Osmotic laxatives are the cornerstone of medical therapy and can be intermittently alternated with transit-stimulating laxatives. Megarectum due to obstructive defecation or anismus can benefit from biofeedback therapy. The treatment of choice for refractory cases is surgery, with colectomy with ileoanal pouch and proctectomy or vertical reduction rectoplasty being the most suitable procedures for megacolon and megarectum, respectively.

RECOMMENDED REFERENCES

1. Gattuso JM, Kamm MA. Clinical features of idiopathic megarectum and idiopathic megacolon. *Gut* 1997; 41: 93-9.
2. Szarka LA, Pemberton JH. Treatment of megacolon and megarectum. *Curr Treat Options Gastroenterol* 2006; 9: 343-50.
3. Real Martínez Y, Ibáñez Moya M, Pérez Mota A. Megarectum and anismus: a cause of constipation. *Rev Esp Enferm Dig* 2007; 99: 352-3.
4. Gladman MA, Scott SM, Lunniss PJ, Williams NS. Systematic review of surgical options for idiopathic megarectum and megacolon. *Ann Surg* 2005; 241: 562-74.