Surgery for congenital megacolon in a twenty-two year old male

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ABSTRACT
Surgery for congenital megacolon in an adult is rare. It is usually a Paediatric age group surgical procedure. Occasionally, patients present with this problem at a later age. In the recent past we operated upon a 22-year-old male with this condition.

KEY WORDS
Adult Hirschsprung’s disease, Chronic intestinal obstruction.

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CASE REPORT
A 22-year-old male presented with clinical picture of chronic constipation and subacute intestinal obstruction. The history was Mr. N., born during December 1977. He did not pass meconium soon after birth. He developed distension of abdomen on the second day after birth. There were no external anomalies in the anal region. After Per rectal examination a little amount of meconium was passed. The distension persisted. Paediatric surgical consultation revealed diagnosis of congenital megacolon and surgery was advised.

In view of the surgical risk involved the consent for surgery was not given. Repeated periodic enema and washouts were giving temporary relief. The patient demanded a permanent solution for his problem and was willing for surgery at the age of twenty two.

Clinical Examination revealed subacute intestinal obstruction.

Clinical /Biochemical investigations were normal. Plain X-ray: showed distended loops of large intestine. Barium Enema showed narrowed smooth distal colon, grossly distended loops of sigmoid colon (figure 1). Multiple filling defects in colon, due to the hardened faecal matter were noted.

TREATMENT
Abdominal exploration revealed a dilated, thickened long sigmoid loop. Terminal six inches of the sigmoid colon was not hypertrophied. Biopsy of bowel wall from
this segment confirmed the condition. Colostomy in the right half of transverse colon was performed. Twelve weeks later the abdomen was reopened through a subumbilical midline incision.

The proximal half of sigmoid colon was dilated, thickened and was containing three large (5.0 x 5.0 cms), hard barium mixed faecal concretions. At a point about 5.0 cms proximal to the dilated part, the colon was transected (proximal) and sufficient length of gut, proximal to the transection, was mobilised to bring it down to anal canal, without tension.

An anterior midline incision was given in the muscle coat of rectal wall, keeping the mucosal layer intact. By blunt dissection, an intact mucosal tube was dissected. The incision in the muscular layer was extended round the gut, transecting the muscle coat. The upper end of the mucosal tube severance completed the gut transection (distal). The dilated, thickened loop of colon between transections was excised along with barium mixed faecal concretions in its lumen. The divided upper end of the rectal mucosal tube was closed by a catgut suture and inverted into the distal gut lumen and brought out through the anus. The cut end of the proximal normal colon was drawn into anal canal, through the mucosa - denuded - rectal sleeve . The seromuscular layer of the unopened colon was sutured to the anal muscular coat with 4-0 vicryl. (Denda 1965).

The end of the pulled through colon was opened and its mucosa was sutured to mucosa of rectum. Through the abdominal route the upper cut edge of the rectal muscular sleeve was sutured to wall of the colon segment passing through it, to relieve tension on colo anal anastomosis site.

Drains for peritoneal cavity provided. Abdomen was closed. Patient started passing, per anum, small amounts of mucus and barium from fourteenth and motion from eighteenth postoperative day. The proximal colostomy was closed on the twenty first postoperative day. Patient started passing normal motion from the second day following colostomy closure. Review after one year and three months revealed no anal stenosis. Bowel movements were normal and patient was happy with the procedure. Barium enema revealed normal calibre of the bowel (Figure 2).

DISCUSSION

Adult patients presenting for treatment of Hirschsprung’s disease is a rare entity. The condition needs to be suspected in cases of severe constipation since birth. Barium enema shows rectal narrowing in 77% and colonic dilatation in 100%. (Anuras et al 1984). The condition is more common in males. Lahey clinic reported five adult cases during the period between 1983 and 1991. (Wu JS et al 1995). Tissue biopsy establishes the diagnosis.

Among the available surgical procedures excision of the thickened colon proximal to the narrowed segment and pull through of the proximal normal colon, through a mucosa denuded rectal cuff to anal canal, as described by Danda/Scott Boley (sutured Soave technique) was considered safe. It also obviates the need for extensive pelvic dissection, which would be hazardous in male patients. Hence this procedure of Danda/Scott was performed. The result is satisfactory. A review after one year and three months did not reveal any stenosis or any other problem. In view of rare presentation of the condition at that age, the case is reported.

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REFERENCES