

Megabowel and Giant Fecaloma: a Surgical Condition?

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A 79-year-old patient presented to the emergency room for progressive abdominal distension and shortness of breath. He had no significant past medical history except for chronic constipation for which he was not compliant with his medication. He had not had a bowel movement over the preceding 2 months. His vitals were normal but he displayed a restrictive respiratory pattern. Upon physical examination, we found a non-tender but severely distended abdomen, considerable fecal impaction, and signs of bilateral peripheral edema. At this point, we suspected a giant fecaloma with megabowel. This was confirmed by an abdominal series, which showed severe sigmoid distension with fecal residue. A computed tomography was performed and revealed a megasigmoid with fecal impaction reaching the right hypochondriac region (Fig 1). The sigmoid loop measured 22 cm at its largest diameter. The liver and remaining viscera were upwardly displaced (Fig. 2). There was compression of the iliac venous system and the left pelvic ureter with hydronephrosis. There were no signs of bowel pneumatosis, volvulus, or parietal thickening. Laboratory tests also confirmed the compressive nature of the fecal impaction with mild leukocytosis, cholestasis, lactic acidosis, and acute kidney failure. Volume resuscitation was initiated and a surgical approach was discussed with the patient from the start. The decision of an initial surgical treatment was based on the patient age, history of chronic constipation, megabowel, and significant fecal impaction with venous and ureteral compression. With his consent, a

Hartmann procedure was performed not without challenge. The distended sigmoid loop was casted in the right diaphragm with the liver lifted anteriorly making its extraction difficult despite a median xyphopubic incision. A sigmoid colotomy was performed in order to evacuate gas and manually extract feces without spillage. An 8-cm wide megarectum tenia was measured at the sacrum level (Fig. 3). It was stapled after dissecting away the left ureter. A terminal colostomy was easily performed given the normal width of the left colon. Postoperative care was uneventful with return to normal transit, recovery of renal function, regression of hydronephrosis, and relief of peripheral edema. The patient subsequently reported a good quality of life. The pathology report confirmed an idiopathic megacolon. The

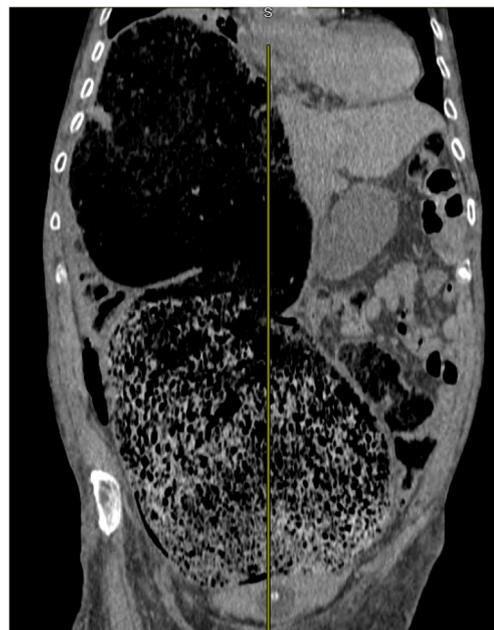


Fig. 1 Abdominopelvic CT scan, coronal view, without injection of product contrast: giant fecaloma extending from the lower rectum to the right diaphragmatic region. The liver is repressed medially; the rest of bowel and left colon are flat and compressed. The bladder is compressed, and a catheter solves the chronic retention

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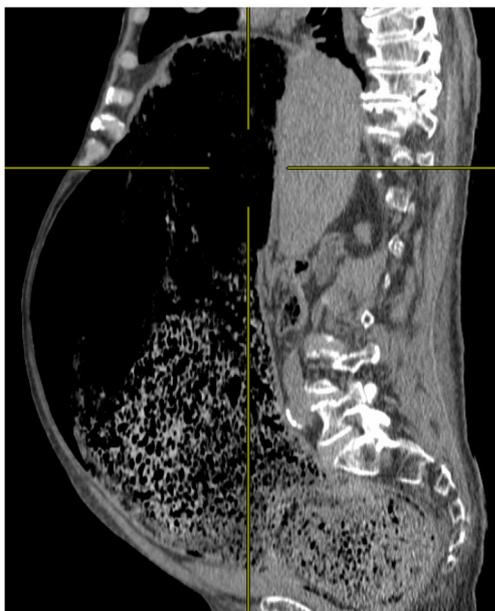


Fig. 2 Abdominopelvic CT scan, sagittal view, without injection of product contrast: giant fecaloma extending from the lower rectum to the right diaphragmatic region. The liver is repressed posteriorly; the left colon is flat and compressed

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The incidence of chronic megacolon (MG) and fecal impaction in the general population is unknown. Increased diameter and/or increased length of the colon define the idiopathic MC (IMC) when other etiologies have been excluded (Chagas

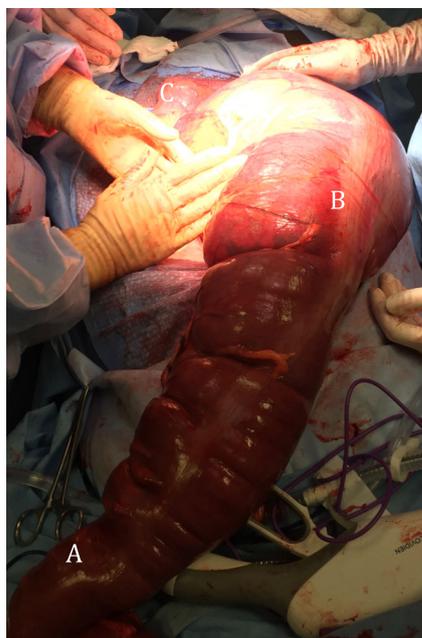


Fig. 3 Photography of operative site: (a) sigmoid loop is divided at its junction with the left colon for a mechanical stapler. The anterior colonic tenia is widened (b); the sigmoid loop is in continuity with the rectum, seat of a fecal impaction making difficult the pelvic dissection (c)

disease, Hirschsprung disease, use of neuroleptics). It affects both genders and all ages. Predominant symptoms of IMC are constipation, abdominal pain, distension, and gas distress. Pathophysiology, natural history, and effective management are not well defined. Patients with IMC have an excessive laxity compliance, colonic hypomotility, and/or sensorial rectal dysfunction. Most affected patients can be treated with a medical regimen including a high-fiber diet, laxatives, and biofeedback perineal reeducation. However, medical treatment fails to restore normal bowel caliber. A majority of patients may need a surgical treatment to alleviate their symptoms or to treat complications such as ulceration, perforation, volvulus, obstruction, fecal impaction, and adjacent organ compression. Although a number of procedures have been described,¹ high-quality evidence on the best surgical management of IMC is lacking. In the case we present, a Hartmann procedure was performed mainly to avoid a discrepancy between the proximal and distal ends of a colorectal anastomosis. Gladman et al.² report success rates of about 50% in cases of segmental resection with less than 25% recurrence of symptoms. Elective procedures for megabowel are best performed by colorectal surgeons. However, our experience suggests that a Hartmann procedure is accessible and safe in an urgent setting, with less morbidity and mortality than a subtotal colectomy with ileorectal anastomosis.

Author Contribution Studer AS: conception, design, and draft of the case; collection and analysis of data; literature background and analysis

Loneragan AM: revisions critically for important intellectual content and corrections

Le Guillan S: analysis and interpretation of data for the work and revising it critically for important intellectual content; correction and final approval of the version to be published

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The institutional board approved this article in accordance with ethical standards and 1964 declaration of Helsinki.

Conflict of Interest The authors declare that they have no conflict of interest.

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