CLINICAL PRACTICE

Clinical Images

Chronic Constipation with Megacolon

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Figure 1. CT scan showing severe colonic distention from stool.

A 61-year-old female with long-standing constipation presented with increasing abdominal distention, pain, nausea and weight loss. She had been previously treated with intermittent fiber supplements and osmotic laxatives for chronic constipation. She did not use medications known to cause delayed bowel transit. Examination revealed a distended abdomen, hard stool in the rectum, and audible heart sounds throughout the abdomen. A CT scan showed severe colonic distention from stool (Fig. 1). She had no mechanical, infectious, metabolic, or endocrine-related etiology for constipation. After failing conservative management including laxative sup-

Figure 2. Surgical specimen (colon).

positories, enemas, manual disimpaction, methylnaltrexone and neostigmine, the patient underwent a colectomy with Hartmann pouch and terminal ileostomy. The removed colon measured 25.5 cm in largest diameter and weighed over 15 kg (Fig. 2). The histopathological examination demonstrated no neuronal degeneration, apoptosis or agangliosis to suggest Hirschprung's disease or another intrinsic neuro-muscular disorder. Idiopathic megacolon is a relatively uncommon condition usually associated with slow-transit constipation. Although medical therapy is frequently ineffective, rectal laxatives, gentle enemas, and manual disimpaction can be attempted. Oral osmotic or secretory laxatives as well as unprepped lower endoscopy are relative contraindications as they may precipitate a perforation. Surgical therapy is often required as most cases are refractory to medical therapy.

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