

Diagnosis and management

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Megarectum may present with a mass the size of a full-term baby (Figure 73.9) but diagnosis is mainly radiological. The mainstay of management of both (in brief) requires getting the rectum empty . In some patients with megarectum this may require manual disimpaction under anaesthesia. Thereafter, high doses of regular osmotic and stimulant laxatives orally as well as regular enemas (or high-volume transanal irrigation (TAI); see Constipation) are required to keep it empty . Prokinetics may also have a role. Compliance with medication is often an issue in young patients with psychobehavioural problems. Surgery has an important role in patients who fail medical management. Colectomy or subtotal colectomy is generally required for megacolon. A variety of options exist - - - - vioural - for megarectum. A first step may be an antegrade colonic enema (ACE) procedure (see Constipation). If this fails, definitive surgery includes pull-through procedures, low anterior resection, restorative proctocolectomy and rectum-reducing procedures, e.g. vertical reduction rectoplasty . All should be undertaken with covering loop ileostomy and many advocate performing an ileostomy for 6 months to 1 year prior to surgery . This allows the rectum to shrink and reduce in vascularity , making eventual surgery safer; some patients may also simply

oderma s disease (congenital megarectum) s disease (post reconstruction) Figure 73.9 Plain abdominal radiograph of a teenage male with megarectum.

The hazard of operating on a rectum that occupies the whole pelvis with serosal veins that sometimes resemble the iliac veins cannot be underestimated and surgery should be performed in specialist centres.

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