at the time of the primary surgery itself is recommended to prevent this rare but potentially disastrous complication.4

References

Congenital segmental dilatation of colon with colonic atresia
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Congenital segmental dilatation of the colon belongs to a group of Hirschsprung’s-like diseases with normal ganglion cells. The presentation is with chronic constipation affecting older children. We report a neonate with congenital segmental dilatation of the colon associated with sigmoid atresia. The child is well after a colostomy. [Indian J Gastroenterol 2005;24:123-124]

Congenital segmental dilatation of the colon belongs to a group of Hirschsprung’s-like disease with normal ganglion cells.1 Most cases reported are older children (6 mo to 22 y) presenting with chronic constipation.2,3 Only three cases have been reported in the neonatal period.4 Ileal dilatation with colonic atresia has been reported,5 but association of colonic atresia with segmental dilatation of the colon has not been reported yet.

A 2.3-Kg full-term boy was born of normal delivery to a 24-year-old mother. The neonate presented to us at day 2 of life with severe abdominal distension and failure to pass meconium. He had one episode of nonbilious vomiting. No dysmorphic features were noted. Examination revealed a 6 cm x 8 cm mass in the upper abdomen. X-ray showed a huge gas shadow in the upper abdomen.

After resuscitation, the child was taken up for laparotomy, which revealed loops of small bowel pushed to the left lower quadrant. The ileum opened into a normal cecum. The ascending colon was continuous with a hugely dilated segment of transverse colon; the descending colon was normal. There was atresia (type II) of the sigmoid colon. No taenia could be identified in the dilated segment. There were multiple tortuous serosal vessels on the dilated segment (Fig).

Proximal colostomy was done. The sigmoid atresia was repaired by end-to-end anastomosis. The dilated segment was plicated and a biopsy was taken. Microscopic examination showed normal ganglion cells; there was no muscular hypertrophy or submucosal fibrosis. The child is thriving well on the colostomy.

Since the first case described by Swenson and Rathausers,6 only 13 additional cases of segmental dilatation of colon have been described. Most were older children who presented with chronic constipation.

The left side of the colon is affected more frequently, with sigmoid and rectosigmoid involvement in 45% of cases.3,4 In our patient there was segmental dilatation of the transverse colon with atresia of the sigmoid colon. Segmental dilatation of the ileum with colonic atresia has been reported earlier.5 But association of segmental colonic dilatation with colonic atresia has not been reported.

Segmental dilatation of the colon belongs to the group of disorders related to Hirschsprung’s disease but without any abnormality of ganglion cells. Included in this group are idiopathic megacolon, pseudo Hirschsprung’s disease (ehrenpresis), and achalasia of the distal rectum.1,2

Brawner and Shafer1 summarized the clinical and pathologic features as: i) lack of radiographically demonstrable motility of the dilated segment; ii) normal appearing and functioning colon both proximal and distal to the dilated segment; iii) absence of taenia coli in the dilated segment; iv) normal ganglion cells; and v) hypertrophy of the circular and longitudinal muscle layers in the dilated segment.
The absence of muscular hypertrophy in the dilated segment in neonates has been attributed to it being an functional adaptation to chronic obstruction and not a part of the congenital malformation.1,6

A striking feature is the abundant tortuous serosal vascular pattern on the dilated segment, which has been found in all cases. A vascular catastrophe has been suspected to lead to this malformation.7

A neurogenic factor with normal ganglion cells, strangulation of intestine at the umbilical ring, hypoplasia of intestinal muscles, impairment of intestinal organ genesis, a common pathogenetic complex with congenital diverticula and duplication, deranged chemoreceptor and abnormal muscle development, presence of heteroplastic tissue in the wall of the dilated segment have all been postulated as possible causes of segmental dilatation of colon.4

Associated malformations reported are of the ventral spine, meningomyelocele, cleft palate, congenital heart disease, malformation of the lungs and esophagus, duodenal atresia, annular pancreas, Meckel’s diverticulum, bladder extrophy and genital malformations.4

The recommended treatment is resection of the dilated segment and end-to-end anastomosis with proximal colostomy to avoid a major procedure in a sick neonate.

References

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Enteral feeding by fistuloclysis in a midjejunal fistula
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Enterocutaneous fistulas are potentially life-threatening complications of gastrointestinal surgery. Nutritional support is the mainstay of management. We report a 32-year-old man who developed an enterocutaneous fistula following surgery for ulcerative colitis. Enteral feeding was attempted by introducing a Foley’s catheter through the midjejunal fistula. [Indian J Gastroenterol 2005;24:124-125]

Gastrointestinal fistulas, with their associated fluid and electrolyte loss, nutritional depletion and sepsis, present a major challenge to the treating surgeons.1,2 Since the advent of enteral as well as total parenteral nutrition (TPN), the mortality of GI fistulas has been significantly reduced.1,3,4 We report a patient with midjejunal fistula who was managed by a novel method of introduction of an enteral feeding tube directly through the fistula (fistuloclysis).

A 32-year-old man was admitted with fulminating ulcerative colitis with severe lower gastrointestinal bleeding. Colonoscopic evaluation revealed severe pancolitis and biopsy was reported as fulminant ulcerative colitis. He was given a trial of conservative management initially, with systemic hydrocortisone, oral mesalazine and antibiotics for 10 days. One course of infliximab (Remicade; Schering-Plough) was also tried. All these measures failed and the patient’s condition deteriorated. He was then taken up for emergency total colectomy and temporary ileostomy. The distal end of the rectum was brought out as a mucus fistula through the lower end of the midline wound. The postoperative period was uneventful and the patient was discharged from hospital after two weeks. A definitive reconstruction was planned after three months in the form of ileal pouch-anal anastomosis.

Two months later the patient presented with intestinal obstruction. An initial trial of conservative management failed and after 72 hours he was taken up for emergency laparotomy. During laparotomy, dense adhesions were present between the loops of jejunum and previous midline incision. One loop of jejunum was densely adherent around the ileostomy loop. While releasing this loop, a small rent was found over the adherent jejunal loop. The rent was closed in two layers.

On the seventh postoperative day, the patient developed an enterocutaneous fistula that manifested as bilious drainage from the drain tube. It was a high-output fistula draining about 2500 mL/day. The patient was taken for relaparotomy immediately. A midjejunal fistula was found and was closed in two layers. After 5 days, it leaked again, draining about 2500 mL/day. The patient was put on TPN and antibiotics; over the next three weeks, the fistula output remained high and the general condition of the patient started deteriorating.

A relaparotomy was done at this stage. All the small bowel loops were densely adherent and it was not pos-